Commonwealth of Kentucky
Public Employee Health Insurance Program
Fourth Annual Report

Prepared for:

Commonwealth of Kentucky
Governor
General Assembly
And
Chief Justice of the Supreme Court

October 1, 2004

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Executive Summary

Scope and Process

In accordance with the provisions of KRS 18A.226(5)(b), enacted by the 2000 General Assembly as a part of Senate Bill 288, this document comprises the fourth annual report from the Kentucky Group Health Insurance Board to the Governor, the General Assembly, and the Chief Justice of the Supreme Court. In addition to the Board's recommendations, it includes:

- Summary experience for the Commonwealth's Public Employee Health Insurance Program (PEHI) during calendar year 2003.
- A discussion of the recommendation of some Board members that the Commonwealth view the competitiveness of its health insurance benefits in the context of its total compensation program, rather than a stand alone basis.
- A discussion regarding the need to make available information with respect to provider quality, cost and treatment alternatives to PEHI members.
- The rationale for health promotion and disease management programs.
- An analysis of the impact that "unescorted retirees" have on the cost of the Public Employee Health Insurance Program.
- Board members' concerns about the impact of the Commonwealth's planned reduction in the amount funded in a healthcare flexible spending account (FSA) for employees who waive health insurance through the Commonwealth.
- In accordance with HJR 207 and SJR 111, a study of Health Reimbursement Accounts (HRA's). Additionally, this section of the report also includes a review of Health Savings Accounts (HSA's).
- An outline of the timing of the Board's Annual Report, in relation to other activities that impact the PEHI program.
- Information regarding Public Employee Health Insurance Program governance and administrative issues.
- Summaries of legislated health insurance benefit mandates and mandates passed by the 2002, 2003, and 2004 General Assemblies that affect the Public Employee Health Insurance Program.

To prepare this report, research was conducted by the Department for Employee Insurance and Mercer Human Resource Consulting and presented to the Board at its monthly meetings. Based on these presentations and the Board's articulated recommendations, the report was drafted by Mercer Human Resource Consulting on behalf of the Board and modified to incorporate the Board's comments.

Please refer to the *Glossary* at the end of the report for definitions of terms used in the body of the report.

2004 Board Recommendations

Following a thorough review of the Commonwealth's Public Employee Health Insurance Program, the Kentucky Group Health Insurance Board makes the recommendations outlined in this section. These recommendations are presented in four primary categories:

- Consumer information and education,
- Health benefit provisions,
- Program governance, and
- Program administration.

The rationale for the recommendations in each of these sections is summarized briefly prior to the recommendations. Detailed findings from the comprehensive analysis conducted by the Board, upon which these recommendations are based, are provided in the individual sections of this report. These findings are summarized in the final section of this report, under Conclusions.

Consumer Information and Education

Little information is currently made available to Public Employee Health Insurance members about health care services, products, prices, quality or relative value. They do not know what different hospitals and physicians charge, nor which provider offers the highest quality and best value. Furthermore, members with chronic health conditions often do not receive sufficient information about how to best manage their condition or may not know how to apply this information in their every day choices. Finally, studies indicate that an individual's behavior and lifestyle choices account, in general, for 50% of an individual's health status. This, coupled with the poor health status of Kentuckians overall, suggests that PEHI members could benefit from health promotion and disease management programs.

Therefore, the Board recommends that:

- The Commonwealth investigate ways to promote PEHI members' access to:
  - provider quality information;
  - provider cost data; and
  - the cost and relative value of alternative health services and prescription drugs.
- The Commonwealth implement initiatives to educate PEHI members on:
  - the positive impact of healthy lifestyle choices;
  - how to best manage their chronic health conditions; and
  - how to make informed health care decisions.
- The Commonwealth actively promote initiatives that support healthy lifestyle behaviors.

Health Benefit Provisions

With the changes other employers made to their health plans from 2000 to 2003, overall, with the exception of its dependent health insurance contributions, the Commonwealth's 2003 health insurance program was more generous than the median of the large employer market nationally and state government employers. Given anticipated changes, based on employers' responses to recent surveys, in 2004, it is expected that the provisions in the Commonwealth's Option A health offerings will be even further above average when compared to those of large, national employers and state government employers. However, some Board members feel that it is important for the Commonwealth to view its health insurance benefits in the context of its total compensation program. In this context, these Board members generally believe that the Commonwealth's health benefit plan provisions must be above the median of the market to attract and retain qualified employees.

Although the Board recognizes the Commonwealth's budgetary pressures, it is concerned about the impact that the changes in the benefit provisions and the implementation of single health insurance employee contributions planned for calendar 2005 will have on employees and retirees. This concern is heightened by:

- the length of time that the Commonwealth's policy of paying the full cost of single health insurance coverage has been in place, and
- a belief that the compensation of the Commonwealth's employees is below the midpoint of the market for comparable positions.

HJR 207 and SJR 111 required the Board, in conjunction with the Personnel Cabinet, to conduct a study to determine if a health reimbursement arrangement would provide a benefit to employees and reduce employer costs for health insurance. Based on its analysis, the Board recommends that the Commonwealth continue to explore these types of arrangements, as better access to health services and provider cost and quality information becomes available.

Anecdotally, some Board members have heard that, due to the magnitude of employee contributions for dependent health insurance, some Commonwealth employees have opted to waive health insurance coverage through the PEHI program and use the healthcare FSA funded by the Commonwealth to pay their family's health care expenses. These stories create Board concerns about the reduction in healthcare FSA funding for employees who waive health insurance that is planned for 2005.

In summary, the Board recommends, that the Commonwealth:

- View the competitiveness of its health insurance benefits in the context of its total compensation program, rather than a stand alone basis.
- Explore ways to minimize employees' out-of-pocket expenditures for health insurance benefits – both employee premium contributions and cost-sharing at the time services are received – when revenues become available.
- As health services and provider cost and quality information become available to PEHI members, continue to study health reimbursement accounts (HRA's) to determine if an arrangement that includes these accounts would provide a benefit to employees and reduce employer costs for health insurance.

- Analyze the impact of the Commonwealth's 2005 planned reduction in healthcare flexible spending account funding for employees who waive health insurance through the PEHI program.

Program Governance

The percentage of Public Employee Health Insurance members that retirees and their covered dependents comprise grew from 14.3% in 1999 to over 20% by the end of the first quarter of 2004. Due to the impact of age on individuals' health care costs, this trend has significant cost implications for the Commonwealth's Public Employee Health Insurance Program. This impact is exacerbated by the entities whose retirees participate in the Commonwealth's program whose active employees do not – municipalities and other local governmental bodies and regional universities that participate in a state-sponsored retirement plan. The Board's October 2002 report, supported by an independent analysis conducted by The Segal Company at the request of the Interim Joint Committee on State Government, indicated that these "unescorted" retirees added between $14 and $16 million in excess claims to the Public Employee Health Insurance Program in 2001. In 2003, this additional claims cost is estimated at about $21 million, which increased the total cost of the PEHI program about 3.3% from what it would have been had these "unescorted retirees" and their dependents not been covered under the PEHI program.

Currently, the Board is required to submit its recommendations to the Governor, General Assembly and Chief Justice of the Supreme Court by October 1 of each year. As contracts for the PEHI program's calendar 2005 plan year were not executed until mid August, the Board was left with a very short timeframe in which to ensure that this report reflected appropriate recommendations and analysis considering the significant changes occurring in the PEHI program in 2005.

In summary, the Board recommends:

- To protect the financial integrity of the Public Employee Health Insurance Program, the Commonwealth require entities whose retirees participate in the Commonwealth's Public Employee Health Insurance Program and whose active employees do not to be responsible for the actuarial difference in cost of their retirees.

- The deadline for the Board's submission of its annual report be revised from October 1 to December 1.

Program Administration

To encourage insurance carriers and/or third party administrators to provide good quality service to Public Employee Health Insurance Program members, the Department for Employee Insurance, and its benefit coordinators, the Commonwealth has incorporated performance guarantees in its health insurance contracts, with monetary penalties if performance standards are not met. The Department for Employee Insurance receives periodic reports from each of the Commonwealth's health insurance carriers outlining their performance in relation to the performance guarantees to which they agreed and holds meetings and conference calls with the insurance carriers, as necessary, for continuous quality improvement. However, the Board feels that the Commonwealth's ability to monitor the performance of its insurance carriers and recommend revisions to improve performance over time could be enhanced if audits were conducted by the Commonwealth, or an independent third party, periodically to verify carriers' and/or third party administrators' reported performance results.

As part of continuous quality improvement, the Board recommends that the Commonwealth conduct audits to validate financial and performance results reported by the Commonwealth's Public Employee Health Insurance Program insurance carriers and/or third party administrators. Furthermore, the Commonwealth should ensure that meaningful penalties apply to sub-standard performance.

Background and History

The *Health Insurance Market for Employees and Retirees of Kentucky State Government – Research Report No. 286*, dated August 12, 1999, prepared by the Program Review & Investigations Committee Staff, provides the following historical information regarding the Commonwealth's Public Employee Health Insurance Program.

> *The Commonwealth first contributed funds for the health insurance premiums of its employees in 1972. From that time until the mid 1980's, Blue Cross & Blue Shield was the only insurance carrier offered to the state group. After experimenting with two HMO plans in 1981 and 1983, the Personnel Cabinet made more than a dozen additional plans, mostly HMOs, available to employees in 1984. Still, the indemnity plan offered by Blue Cross & Blue Shield was the dominant plan chosen. Of the 90,000 employees eligible for state-provided insurance in 1987, 64,000, or 71 percent, were enrolled in the Blue Cross & Blue Shield Key Care indemnity plan.*
>
> *In September 1987, Blue Cross & Blue Shield notified state officials of its intention to cancel the Key Care plan on October 15, 1987. This led to a decision by state policymakers to self-fund the healthcare program under the name Kentucky Kare.*
>
> *Note: The Commonwealth first contributed funds for the health insurance premiums of teachers in 1972. However, the Commonwealth began contributing funds for the health insurance premiums of other state employees prior to 1972.*

As part of extensive changes to health insurance laws adopted in HB 250, the 1994 General Assembly established the Kentucky Health Purchasing Alliance (Health Purchasing Alliance), which became effective for Commonwealth Group members effective July 1, 1995. Under the Health Purchasing Alliance, from mid 1995 through 1998, Commonwealth Group members had a choice of five Kentucky Kare options. Additionally, Commonwealth Group members could also choose one of four HMO options, four POS options, or five PPO options all through several insurance carriers.

Due to mounting losses under Kentucky Kare as a result of adverse selection from diminishing enrollment, the 1998 General Assembly enacted House Bill 315, which dissolved the Health Purchasing Alliance effective December 31, 1998. This led to the Commonwealth re-establishing an independent healthcare program, the Commonwealth Public Employee Health Insurance Program, for Commonwealth Group members.

Public Employee Health Insurance Revisions 1999 to 2004

In 1999, the Public Employee Health Insurance Program offered two HMO options (A and B), two POS options (A and B) and two PPO options (A and B) through insured arrangements with seven insurance carriers (Advantage Care, Aetna, Anthem, Bluegrass Family Health, CHA Health, Humana, and Pacificare). Two indemnity plan options were offered to out-of-state retirees through Anthem. These options were continued in 2000, with the following primary revisions:

- An EPO Option C was added to provide an option to Commonwealth Group members with a lower employee premium contribution.
- Aetna was discontinued due to its elimination in the 2000 RFP process.
- A feature was added to all 2000 options that reduced the prescription drug co-payments members had to pay after they had paid 50 co-payments in a year for themselves and covered family members.
- Coverage of outpatient mental health/chemical dependency services was expanded
  - from 30 to 45 visits annually in the A options and
  - from 21 to 36 visits annually in the B options.
- Out-of-state retirees were allowed to elect any POS or PPO option offered by any of the insurance carriers insuring Commonwealth Group members, as no insurance carrier was willing to insure an indemnity plan for these individuals.
- The Commonwealth revised its contribution policy to provide a contribution that was at least equal to the Single premium rate for the lowest cost Option A in every county.

In 2001:

- The insurance carriers offering health insurance coverage to members of the Public Employee Health Insurance Program changed as follows:
  - Aetna was re-introduced as a healthcare option for the Commonwealth Group in twenty-eight counties within the Commonwealth.
  - Anthem expanded its PPO service area for Commonwealth Group members by fourteen counties.
  - Advantage Care ceased to exist.
  - Pacificare stopped offering health insurance to anyone in Kentucky.
  - Bluegrass Family Health expanded its service area for Commonwealth Group members by nine counties.
  - CHA withdrew its HMO and POS options from twenty-three counties. However it newly introduced PPO options in four eastern counties where it previously offered HMO and POS options.
  - Humana discontinued its KPPA HMO for Commonwealth Group members.
- The following changes in benefit provisions were made:
  - Prescription drug co-payments in the PPO B option were reduced. For generic drugs, the member's co-payment decreased from $15 to $10, for brand name drugs from $20 to $15 and for non-formulary drugs from $40 to $30.
  - Members' cost-sharing for diagnostic testing, in a setting other than a physician's office, was changed from 20% co-insurance after the annual deductible was met to a $10 co-payment per visit in the PPO A option.
  - Inpatient day and out-patient visit limits applicable to mental health and substance abuse services were eliminated from all of the Commonwealth Group's health insurance

options, in accordance with House Bill 268, which was enacted by the 2000 General Assembly.

- Coverage of amino acid preparations and low-protein modified food products was added to all of the Commonwealth Group's health insurance options pursuant to House Bill 202, which was passed by the 2000 General Assembly.

In 2002:

- In response to requests from Legislators and members of the Commonwealth's Public Employee Health Insurance Program, the Commonwealth implemented two new requirements as a condition for a health plan to be offered in a county:
  - If one or more hospitals exists in the county and any bidder has at least one of the county's hospitals in its network, every other bidder must have at least one county hospital in its network to be qualified to be offered.
  - The health plan's network must have at least 25% of the largest number of physicians in any bidder's network for that county in order to be qualified to be offered.
- To lessen the potential impact of adverse selection, the Commonwealth stipulated that a health plan's B option premium rates must be at least 5% lower, but no more than 10% lower than the A option premium rates for the same plan type (HMO, POS or PPO) and coverage level (Single, Parent Plus, Couple, Family).
- The following changes in carrier offerings occurred:
  - Like 2001, Anthem expanded its PPO service area for Commonwealth Group members by fourteen counties.
  - Aetna was discontinued as an offering for Commonwealth Group members in eleven counties.
  - While Bluegrass Family Health's HMO and POS options were newly offered in five counties, these options were discontinued in three counties. Bluegrass Family Health's PPO option was no longer available in one county where it was available in 2001. However, this option was newly introduced in eight countries.
  - CHA's HMO and POS options were discontinued in fourteen counties and newly added in thirteen counties. Its PPO options were added in four counties, but discontinued in the four counties where offered in 2001, due to provider contracting difficulties.
  - Humana's HMO and POS options were no longer available in three counties where offered in 2001 and its PPO options were discontinued in ten counties.

In 2003:

- Again, in response to requests from Legislators and members of the Public Employee Health Insurance Program, the Commonwealth tightened the network requirements applicable to 2003 bids:
  - The 2002 RFP hospital requirement was continued.
  - However, to be qualified to be offered in a county in 2003, a health plan had to:
    - have network primary care physicians of at least 25% of the largest number reported by any health plan bidding that plan type in the county and
    - if any bidder had more than five specialists in a county, a health plan must have had network specialist physicians of at least 40% of the largest number reported by any health plan bidding that plan type in the county.
- Aetna did not respond to the Commonwealth's RFP, as it was not willing to continue to provide health insurance to members of the Commonwealth's Public Employee Health Insurance Program. This affected eighteen counties and about 8,500 employees/retirees.
- Anthem withdrew from fifty counties, affecting around 15,600 employees and retirees.
- Bluegrass Family Health extended coverage to eight additional counties. However, due to either the Commonwealth's more stringent network requirements or termination of some providers' contracts, Bluegrass Family Health wasn't an option in six counties in 2003 where it was available in 2002.
- While CHA did not extend its service area to include more Commonwealth counties in its 2003 bid, it did extend its HMO and POS options to 6 additional counties and its PPO option to 46 additional counties. However, it failed to meet the Commonwealth's 2003 network requirements in two counties where it was available in 2002.
- Humana extended coverage (PPO only) to 2 additional Western Kentucky counties for 2003. However, due to its failure to meet the Commonwealth's 2003 network requirements, Humana wasn't an option in 2003 in fourteen counties where it was available in 2002.
- The following benefit revisions became effective:
  - coverage of dental services was limited to care required as a result of an accidental injury and anesthesia and hospital services that are medically required to safely provide dental care for children below the age of nine and persons with serious mental or physical conditions,
  - as specified in SB 152, enacted by the 2002 General Assembly, coverage for hearing aids and related services for persons under the age of 18 for one hearing aid per impaired ear, up to $1,400 every 36 months, was added,
  - revised limits for coverage of low-protein modified foods and medical formulas for individuals with inherited metabolic diseases,
  - coverage of routine vision care was eliminated, and
  - a mail order pharmacy feature was implemented to allow members to receive a 3-month supply of maintenance prescription drugs for a 2-month co-payment.

- Finally, as enacted by the 2002 General Assembly:
  - Through HB 821, PEHI members were allowed to select coverage in a contiguous county and receive the Commonwealth's contribution for that county, if the hospital in the county where member lived and worked did not offer certain services and a hospital in the contiguous county did.
  - Through HB 846:
    - restricted PEHI employees and retirees to one state contribution for health insurance,
    - required entities participating in the PEHI program to sign a contract, with the Personnel Cabinet, and
    - allowed PEHI members to select coverage in a contiguous county and receive the Commonwealth's contribution for that county, if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does (same provision as HB 821).

In 2004:

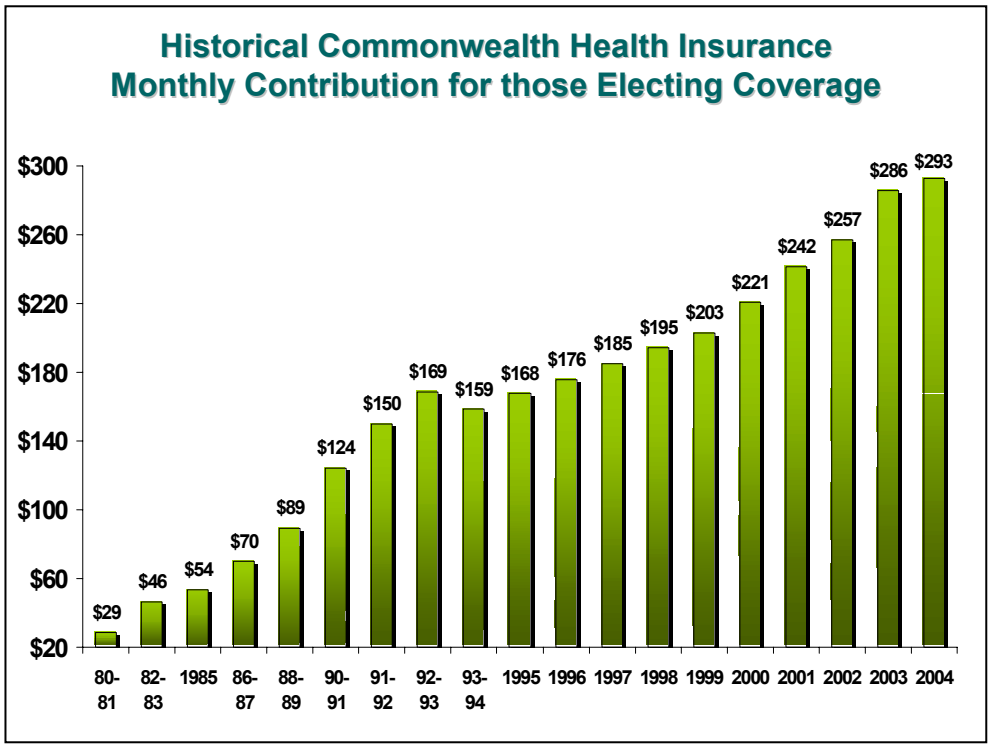
- The 2003 RFP hospital requirement was continued. However, the physician network requirements were modified, such that the specialist physician network requirement only had to be met in counties where at least one bidder reported ten or more specialists, rather than in counties with five or more specialists as applied in 2003.
- The point at which members' prescription drug co-payments are reduced was increased from 50 co-payments per year, for a member and all his/her covered family members combined, to 75.
- Coverage was not available through Anthem under the PEHI program. This affected sixteen counties where Anthem offered PPO coverage to PEHI members in 2003.
- Humana:
  - discontinued offering HMO or POS options to PEHI members, except in six northern Kentucky counties,
  - did not meet the Commonwealth's network requirements with respect to its PPO options, in three counties where it offered PPO coverage to PEHI members in 2003, and
  - newly extended PPO coverage options in forty counties.
- Bluegrass Family Health failed to meet the Commonwealth's network requirements in one county where it offered PPO coverage to PEHI members in 2003. However, it newly extended PPO coverage options in eight counties and HMO and POS options in four counties.
- CHA newly offered HMO, POS and PPO options in two counties.

- Through the Governor's executive order, the Commonwealth provided a health insurance subsidy for employees electing PPO A dependent health insurance under the lowest cost carrier in the 21 counties where the cost of this coverage exceeded the cost in the other 99 counties. This subsidy was set to an amount in each affected county that resulted in all employees paying the same employee contribution, for all coverage tiers, for the lowest cost PPO A option.
- Through legislation enacted by the 2003 General Assembly:
  - Through HB 95, the requirement that an employee's employment must be in the same county as his/her residence for the employee to be eligible to elect coverage in an adjacent county and receive the Commonwealth's contribution for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does, was removed.
  - Through HB 430, the service required for SPRS, CERS and KERS participants to be eligible to participate in the PEHI program was increased from 5 years to 10 years for individuals hired on or after July 1, 2003.

Historical Per Capita Commonwealth Health Insurance Contribution

From $9.75 per covered employee in 1972, the Commonwealth's contribution for employee health insurance grew to an expected average of $293 in 2004. The Commonwealth's per employee contribution from the 1980-1981 plan year through 2004 is reflected in Exhibit I.

Exhibit I

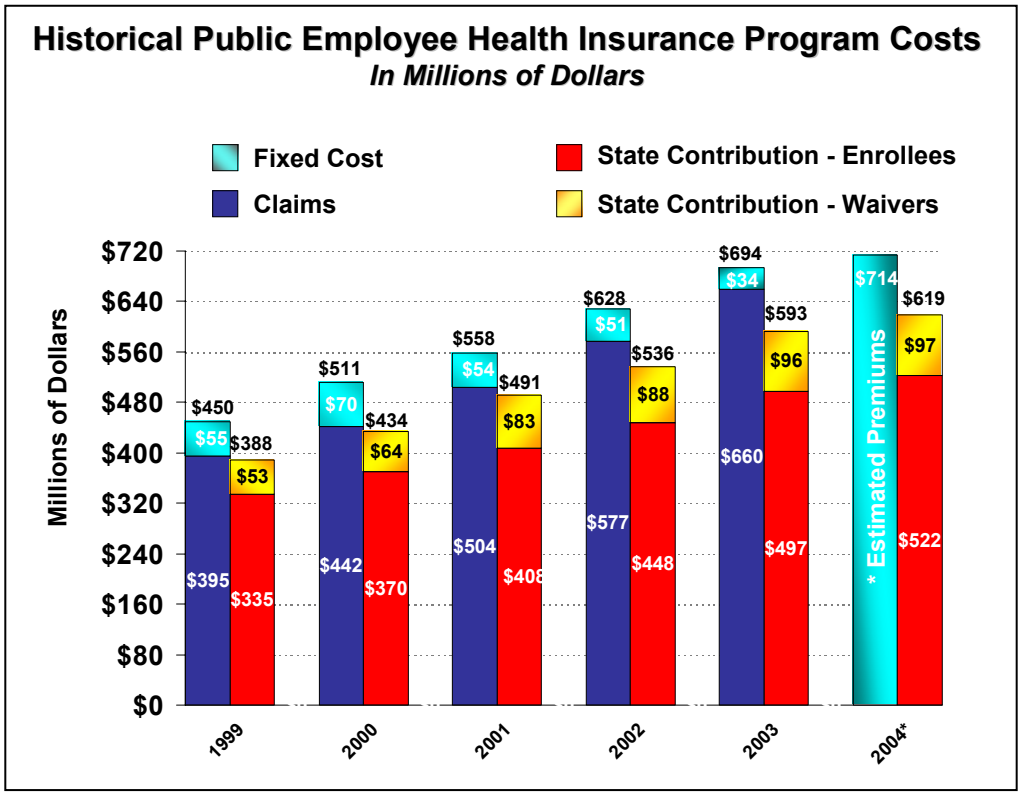


Source: Personnel Cabinet

Public Employee Health Insurance Program Aggregate Costs 1999 to 2004

The total dollars in health insurance premiums (from both employer and member contributions) remitted to the insurers covering members of the Public Employee Health Insurance Program in 1999 through 2004 (estimated) are reflected by the blue bars in Exhibit II. The portion of these dollars actually paid by the Commonwealth's health insurers to healthcare providers for services received by members of the Public Employee Health Insurance Program comprise the dark-blue section of these bars, while the lighter-blue section of each bar reflects the amounts retained by the Commonwealth's insurers for administrative expenses, risk charges and profit. (The actual amounts paid to healthcare providers for services received by members of the Public Health Insurance Program are not yet available for 2004. Therefore, the blue bar shown for 2004 only reflects estimated premiums to be paid to the Commonwealth's health insurance carriers.)

Exhibit II



Source: Claims reported by the Commonwealth's insurers and compiled by MedStat and enrollment reported by the Commonwealth.

Also reflected in Exhibit II are the amounts the Commonwealth expended in 1999 through 2004 for all members of the Public Employee Health Insurance Program. These expenditures are reflected by the red and yellow bars. The red section of each bar reflects the amounts contributed by the Commonwealth for those individuals who elected health insurance through the Commonwealth. The lighter section at the top of each bar reflects the Commonwealth's healthcare flexible spending account contribution for eligible individuals who waived health insurance through the Public Employee Health Insurance Program and contributions to other health insurance for retirees waiving coverage. (Please note that the amounts shown as the

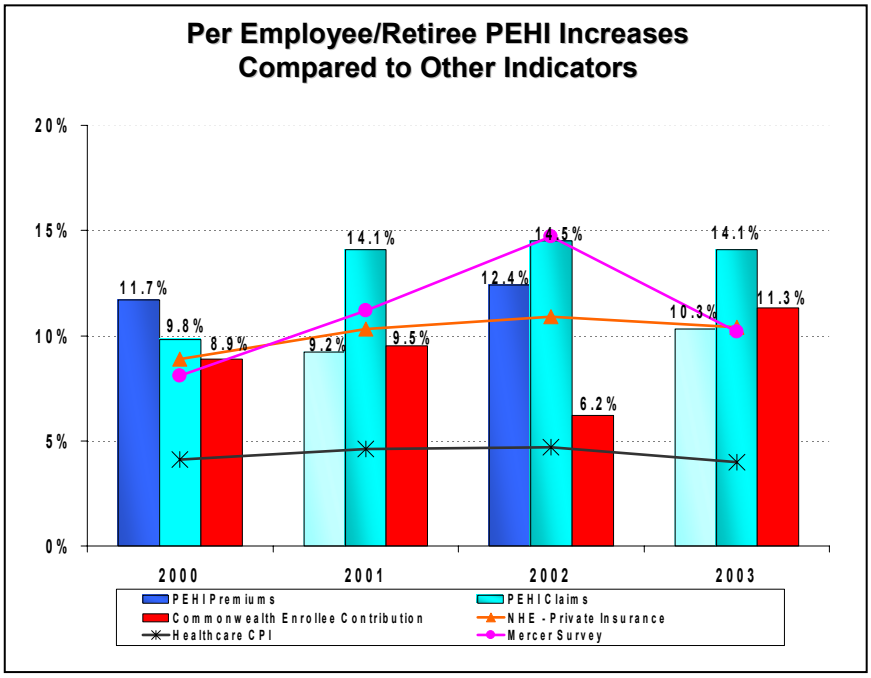
Commonwealth's contribution include the portion of Public Employee Health Insurance Program premiums paid by all of the employers and retirement systems for individuals eligible to participate in the Public Employee Health Insurance Program, ***assuming that all participating groups apply the same employer contribution policy as applies to state and school district employees***. Additionally, the contribution to the healthcare flexible spending accounts of individuals who waived health insurance includes any forfeitures from these accounts. Finally, all retirees are assumed to receive the maximum contribution amount applicable to non-hazardous duty retirees.)

Public Employee Health Insurance Program per Employee/Retiree Cost Increases

For comparison, the per employee/retiree increases in: total premiums for the Public Employee Health Insurance Program from 2000 through 2003 (PEHI Premiums in the chart), total payments to healthcare providers for members of the Public Employee Health Insurance Program (PEHI Claims in the chart), and the Commonwealth's contribution for those enrolling in health insurance (Commonwealth Enrollee Contribution in the chart) are charted in Exhibit III in contrast to the corresponding increases:

- in National Health Care Expenditures for Private Insurance as reported by the Centers for Medicare & Medicaid Services, Office of the Actuary; released in January 2004, based on 2002 data (NHE – Private Insurance in the chart),
- the medical component of the Consumer Price Index (Healthcare CPI in the chart), and
- the percentage increase in employee health insurance costs reported by employers who responded to an annual survey conducted by Mercer Human Resource Consulting (Mercer Survey in the chart).

Exhibit III



Sources: Claims reported by the Commonwealth's insurers and compiled by MedStat and enrollment reported by the Commonwealth were used to develop PEHI Premiums, PEHI Claims and Commonwealth Enrollee Contribution.

U.S. Department of Labor, Bureau of Labor Statistics for Healthcare CPI

Office of the Actuary at the Centers for Medicare & Medicaid Services for NHE Private Insurance

Mercer Human Resource Consulting for Mercer Survey

Commonwealth Public Employee Health Insurance Program
2003 Experience

This section of the report provides a summary of the trends identified from claims and enrollment data submitted by the insurance carriers that provide health insurance coverage to individuals who participate in the Commonwealth's Public Employee Health Insurance Program, as compiled by MedStat.

Restatement of 2002 Experience

Please note that claims for 2002 have been restated from the 2003 report to reflect the actual claims incurred in 2002 that were not paid until 2003. In the 2003 report, these claims were estimated.

A Note About 2003 Experience

Claims for medical services and supplies received by Commonwealth Group members in 2003 that were not paid as of March 31, 2004 have been estimated.

2003 Trends

Key measures for the Commonwealth's 2003 plan year, in comparison to the 2002 year, are provided in Exhibit IV.

Exhibit IV

	Public Employee Health Insurance Program Historical Experience					
	2001	% Change	2002	% Change	2003	% Change
Medical Claims	$399,320,673	12.4%	$453,556,171	13.6%	$515,011,299	13.5%
Rx Claims	$104,247,320	20.6%	$123,337,035	18.2%	$145,208,960	17.7%
Total Claims	$503,567,993	14.0%	$576,893,206	14.6%	$660,220,260	14.4%
Premiums Paid	$558,002,180	9.1%	$627,827,924	12.5%	$694,293,552	10.6%
Covered Lives	225,623	(0.1%)	225,784	0.0%	226,399	0.3%
Per Covered Life						
Medical Claims	*$147.49*	*12.5%*	*$167.40*	*13.5%*	*$189.57*	*13.2%*
Rx Claims	*$38.50*	*20.8%*	*$ 45.52*	*18.2%*	*$ 53.45*	*17.4%*
Total Claims	*$185.99*	*14.1%*	*$212.92*	*14.5%*	*$243.02*	*14.1%*
Premiums Paid	*$206.10*	*9.2%*	*$231.72*	*12.4%*	*$255.56*	*10.3%*
Loss Ratio[1]	90.2%		91.9%		95.1%	

Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance complied by MedStat.

In aggregate, the Commonwealth's health insurance carriers issued payments to medical providers, other than pharmacies, of roughly $515 million for services received in calendar year 2003 by Commonwealth Group members. This represents an aggregate increase of 13.5% over calendar year 2002. This followed a 13.6% increase from 2001 to 2002 and a 12.4% increase from 2000 to 2001.

Higher than marketplace trends, payments for prescription drugs in the Commonwealth's program increased by 17.7%, in aggregate, from $123.3 million in 2002 to $145.2 million in 2003. This followed a 20.6% increase from 2000 to 2001 and an 18.2% increase from 2001 to 2002. In comparison, participants in Mercer's *National Survey of Employer-Sponsored Health Plans* reported aggregate prescription drug cost increases of:

- 16.1% nationally for employers in all industry groups with 500 or more employees (16.9% in 2002; 17.8% in 2001),
- 14.8% for state government employers (15.5% in 2002; 18.2% in 2001), and
- 16.6% for employers located in the South (U.S. census region) with 500 or more employees (16.6% in 2002; 17.9% in 2001).

Note: The increases reported by survey respondents reflect the net increase in cost after taking into account the increases in prescription drug cost sharing implemented by some survey respondents. From 2000 through 2003, there were no increases in members' prescription drug cost sharing in the Commonwealth's program. In fact, prescription drug co-payments in the Commonwealth's PPO B option were reduced in 2001 to make them consistent with the Commonwealth's other B options.

Because prescription drug expenditures have increased at a higher rate than other healthcare expenses, pharmacy service expenditures have grown as a percentage of the Commonwealth's total healthcare expenditures from 19.6% in 2000 to 20.7% in 2001, 21.4% in 2002 and 22% in 2003. In 1999, prescription drugs comprised 18.1% of Commonwealth Group members' healthcare claims.

Total healthcare claims increased in aggregate by 14.4% from 2002 to 2003. This followed an increase of 14.6% from 2001 to 2002 and 14.0% from 2000 to 2001. In 2003, these expenditures totaled a little over $660 million. In 1999, health insurance claims totaled only a little less than $395 million. In just four years, the PEHI program's claims have increased 67%, even though there was little change in the number of covered individuals over that time.

While claim payments to medical providers form the majority of a health plan's expenditures, every health plan, whether insured or self-insured, incurs operational expenses for claims payment, network management, care management and associated services. As the Commonwealth has insured all of its health options since 1999, total expenditures by the Commonwealth and participating Commonwealth Group individuals to purchase health insurance are reflected in the premiums paid to the insurance carriers bearing the risk for the program. In calendar year 2001, these premium payments totaled roughly $558 million. This reflected an increase from 2000 of 9.1%. In calendar year 2002, these premium payments totaled roughly $628 million, an increase from 2001 of 12.5%. In calendar year 2003, premium payments totaled roughly $694 million, reflecting a 10.6% increase from 2002.

For the past three years, payments for medical supplies and services received by PEHI members increased at a faster pace than premiums paid to the Commonwealth's insurance carriers.

Therefore, the loss ratio (incurred claims divided by premiums) increased from 86.4% in 2000 to 90.2% in 2001 to 91.9% in 2002 and 95.1% in 2003. While 13.6% of premiums were retained by the Commonwealth's health insurance carriers in 2000 for operating expenses and profit, this decreased to 9.8% of premiums in 2001, 8.1% in 2002 and only 4.9% in 2003. The 1999 loss ratio was 88.4%, 11.6% of premiums were retained by the Commonwealth's health insurance carriers in 1999.

While the figures provided above reflect changes in aggregate expenditures year over year, it is also important to consider changes in the number of covered lives. The number of employees/retirees insured under the Commonwealth's health insurance program increased roughly 2.0% in 2003. However, like 2001 and 2002, due to a decline in individuals electing dependent coverage, the total number of covered lives insured under the Commonwealth's program remained relatively constant. Although the number of covered spouses declined slightly year over year, in essence, the increase in the number of employees/retirees covered was offset by a decline in the number of children covered. As the average claims cost for a child covered under the Commonwealth's program was roughly 38% of that of an employee/retiree in 2003, part of the Commonwealth's per capita cost increase was the result of this enrollment shift.

Medical claims, exclusive of pharmacy claims, for services and supplies received in calendar year 2003 averaged $189.57 per covered life on a monthly basis. Monthly paid claims per covered life for prescription drugs averaged $53.45 in calendar year 2003. In aggregate, the average monthly paid claims per covered life for services received in 2003 was $243.02. The average monthly premium paid by the Commonwealth and individuals insured under the Public Employee Health Insurance Program was $255.56 in 2003. Because the total number of covered lives – all covered individuals, including dependents – has remained relatively unchanged, the PEHI program's per capita claim and premium increase percentages track aggregate increase percentages fairly closely.

While the Commonwealth's 2001 premium increase of 9.1% was lower than the cost increase reported by employers that participated in Mercer's *National Survey of Employer-Sponsored Health Plans*, the Commonwealth's 2002 premium increase of 12.5% was about one percentage point higher than the average reported by 2002 survey respondents. For 2003, the Commonwealth's premium increase percentage of 10.6% compares to aggregate healthcare cost increases reported in Mercer's 2003 survey of:

- 10.2% nationally for employers in all industry groups with 500 or more employees (11.5% in 2002; 12.1% in 2001),
- 11.3% for state government employers (11.6% in 2002; 13.8% in 2001), and
- 6.5% for employers located in the South (U.S. census region) with 500 or more employees (11.5% in 2002; 12.7% in 2001).

Enrollment Analysis

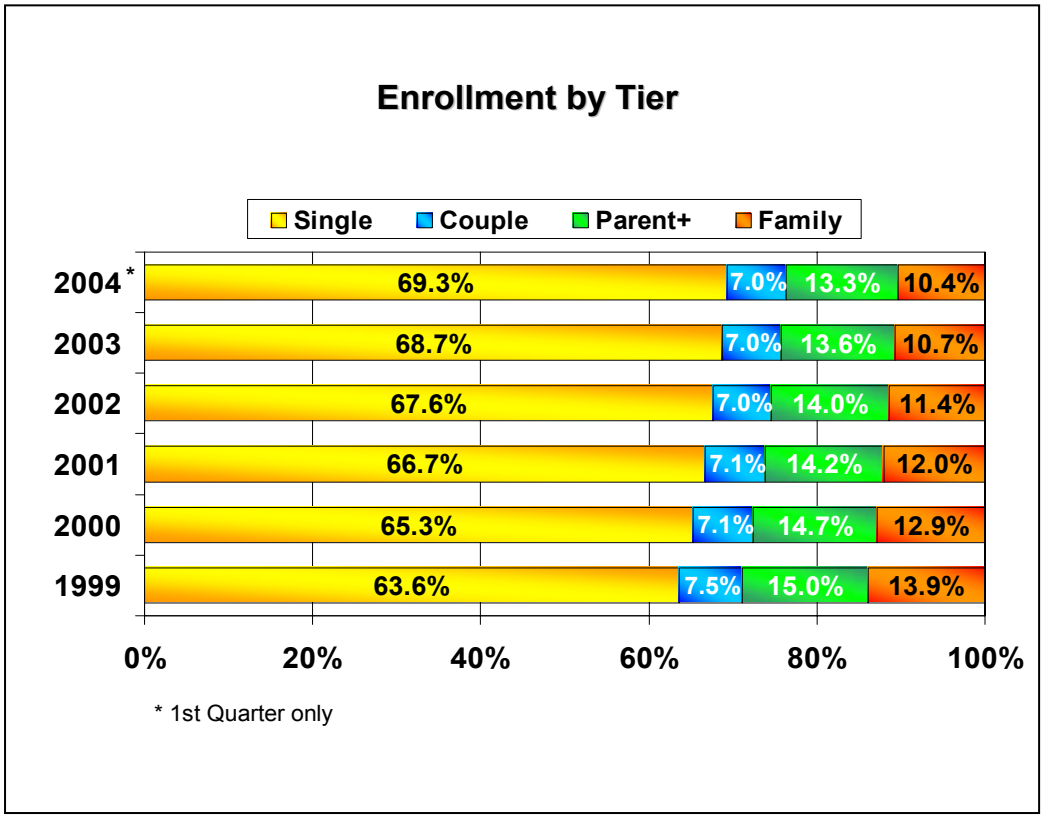
The number of employees/retirees in the Commonwealth Group electing health insurance increased, on average, from 134,112 to 137,024 from 2000 to 2001, to 139,016 in 2002 and 141,822 in 2003. However, the average number of covered lives remained basically constant. In 2000, on average, 17,263 employees/retirees elected Family coverage (coverage for a spouse and one or more children), down from 18,329 in 1999. In 2001, this decreased further to 16,530 and,

in 2002, further to 15,830. Only a slight decline occurred in those electing Family coverage in 2003, to 15,229. The number of individuals enrolled in Couple and Parent Plus coverage remained relatively unchanged from 2000 to 2003, while the number of individuals electing Single coverage increased about 6.5%.

As illustrated in Exhibit V, the percentage of individuals within the Public Employee Health Insurance Program enrolled in Single coverage has consistently increased since 1999, while the percentage of individuals electing dependent coverage, particularly family coverage has consistently declined. This is likely the result of:

- the impact of the Commonwealth's historical contribution structure – the Commonwealth paid the full cost of Single coverage under the lowest cost Option A, but did not directly fund any portion of the cost of dependent health insurance coverage,
- a continuing increase in the number of retirees covered under the program, and
- the aging of PEHI members.

Exhibit V



Source: Commonwealth's enrollment reported by the Department for Employee Insurance and aggregated by MedStat.

Group Composition

The composition of the Commonwealth Group enrolled in health insurance has changed with respect to the key groups that comprise the group overall. Like 2000 over 1999, the number of insured individuals actively employed by state agencies, school boards, and health departments declined from 2000 to 2001. However, the number of individuals insured through KERS and KTRS increased measurably from 1999 to 2000 (10.3%) and from 2000 to 2001 (7.2%). As illustrated in Exhibit VI, this trend continued in 2002 and in 2003, and to a lesser extent still continues in 2004. While retirees and their covered dependents comprised 14.3% of the total insured Commonwealth Group in 1999, by the end of the first quarter of 2004, they comprised 20.1% of the group.

Exhibit VI

	Average Covered Lives by Group (includes dependents)									
	2001	2002		% Change	2003		% Change	2004 – 1st Qtr		% Change
	% of Total	Average Lives	% of Total		Average Lives	% of Total		Average Lives	% of Total	
State Employees	26.0%	57,750	25.6%	(1.7%)	55,765	24.6%	(3.4%)	54,314	23.8%	(2.6%)
School Boards	52.5%	116,038	51.4%	(2.1%)	113,135	50.0%	(2.5%)	112,566	49.4%	(0.5%)
Health Depts.	1.8%	4,091	1.8%	(0.9%)	4,130	1.8%	0.9%	4,080	1.8%	(1.2%)
KERS	9.9%	23,895	10.6%	**7.1%**	26,301	11.6%	**10.1%**	27,857	12.2%	**5.9%**
KTRS	7.1%	16,842	7.5%	**5.1%**	17,554	7.8%	**4.2%**	17,893	7.9%	**1.9%**
KCTCS	1.3%	3,157	1.4%	**6.4%**	3,604	1.6%	**14.2%**	4,080	1.8%	**13.2%**
Quasi/Local Govt	0.6%	2,834	1.3%	**94.9%**	4,757	2.1%	**67.9%**	5,803	2.5%	**22.0%**
COBRA	0.6%	988	0.4%	(32.6%)	1,144	0.5%	15.8%	1,204	0.5%	5.2%
Total		225,959		0.0%	226,390		0.3%	227,797		0.6%

Source: Commonwealth's enrollment aggregated by MedStat.

Due to the impact that age has on individuals' health care costs, as noted the past three years, this trend has significant cost implications for the Commonwealth's Public Employee Health Insurance Program. As illustrated in the Board's 2003 report, in 2002, the average health care expenses incurred by a male in the Commonwealth's program whose age was between 60 and 64 ($5,628) was almost six (6) times that of a male between the ages of 20 and 24 ($967). While not quite as pronounced, the average health care expenses incurred by a female in the Commonwealth's program whose age was between 60 and 64 ($5,522) was over three (3) times that of a female between the ages of 20 and 24 ($1,782).

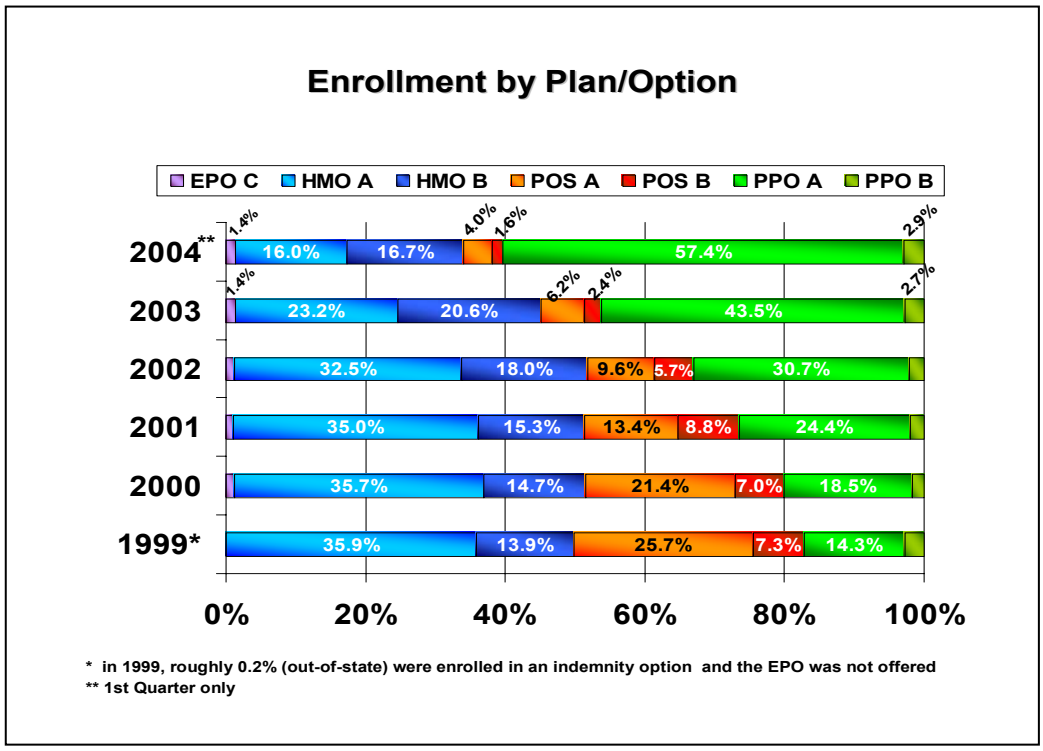
While still not a significant percentage of the total group that participates in the Commonwealth's Public Employee Health Insurance Program, the number of Kentucky Community and Technical College System (KCTCS) insured individuals continues to increase significantly. When KCTCS was formed as an entity separate from the University of Kentucky, individuals in this group were given the option of remaining in the UK benefits package or joining the Commonwealth Group. Individuals hired after this separation have only been eligible to join the Commonwealth's health insurance program. Therefore, since 1999, this group has grown from 2,340 covered lives to 4,080 by the end of the first quarter of 2004.

The number of individuals employed by quasi/local government agencies that are insured under the Commonwealth's Public Employee Health Insurance Program has quadrupled since 2001. As these groups have discretion as to whether to participate in the PEHI program, this growth may be detrimental to the experience of the PEHI program.

Enrollment by Option

The Commonwealth Group's enrollment by plan and option from 1999 through the first quarter of 2004 is illustrated below in Exhibit VII.

Exhibit VII



Source: Commonwealth's enrollment aggregated by MedStat.

The percentage of Commonwealth group members enrolled in HMO Option A remained relatively steady from 1999 through 2001. This began to decline noticeably in 2002 (from 35% to 32.5%), with a more pronounced decline in 2003 (from 32.5% in 2002 to 23.2% in 2003) and 2004 when enrollment in this option is only 16%. Due to a shift to the HMO B option in 2002, the aggregate percentage enrolled in HMO options (both A and B) did not decline until 2003. Until 2003, around 50% of Commonwealth group members chose to enroll in an HMO option. In 2003, this declined to 43.8%. With Humana's withdrawal of HMO and POS options in most areas of the Commonwealth in 2004, the decline in HMO enrollment accelerated, leaving about 32.7% enrolled in HMO A or B. The HMO B option enrollment percentage increased steadily from 1999 (13.9%) to 2003 (20.6%). However, this trend reversed in 2004 when HMO B enrollment dropped to 16.7%, again spurred by Humana's discontinuance of HMO and POS options in most areas of the Commonwealth.

Point of Service (POS) enrollment has declined dramatically each year since 1999. From a high of 33% of the group in 1999, the percentage enrolled in a POS option had declined to only 5.6% by the first quarter of 2004.

PPO Option A enrollment grew from 18.5% in 2000 to 24.4% in 2001. In 2002, PPO Option A enrollment increased significantly to 30.7%. This increase was even more dramatic in 2003 when PPO Option A enrollment grew to over 43% and in 2004, when over 57% of those enrolled in the Commonwealth's Public Employee Health Insurance Program elected PPO option A. The percentage enrolled in the PPO B option has hovered around 2% to 3% since 1999.

The percentage enrolled in the EPO plan, first introduced in 2000, remained virtually constant from 2000 through the first quarter of 2004 (around 1% of the group).

Enrollment by Insurer

The primary change in enrollment by insurance carrier from 2000 to 2001 resulted from the return of Aetna as an offering in 2001 and the exit of Pacificare and Advantage Care from the Kentucky insurance market.

Of the carriers who offered coverage in both 2000 and 2001, only Bluegrass Family Health's (BFH) enrollment percentage increased in 2001. This was due to:

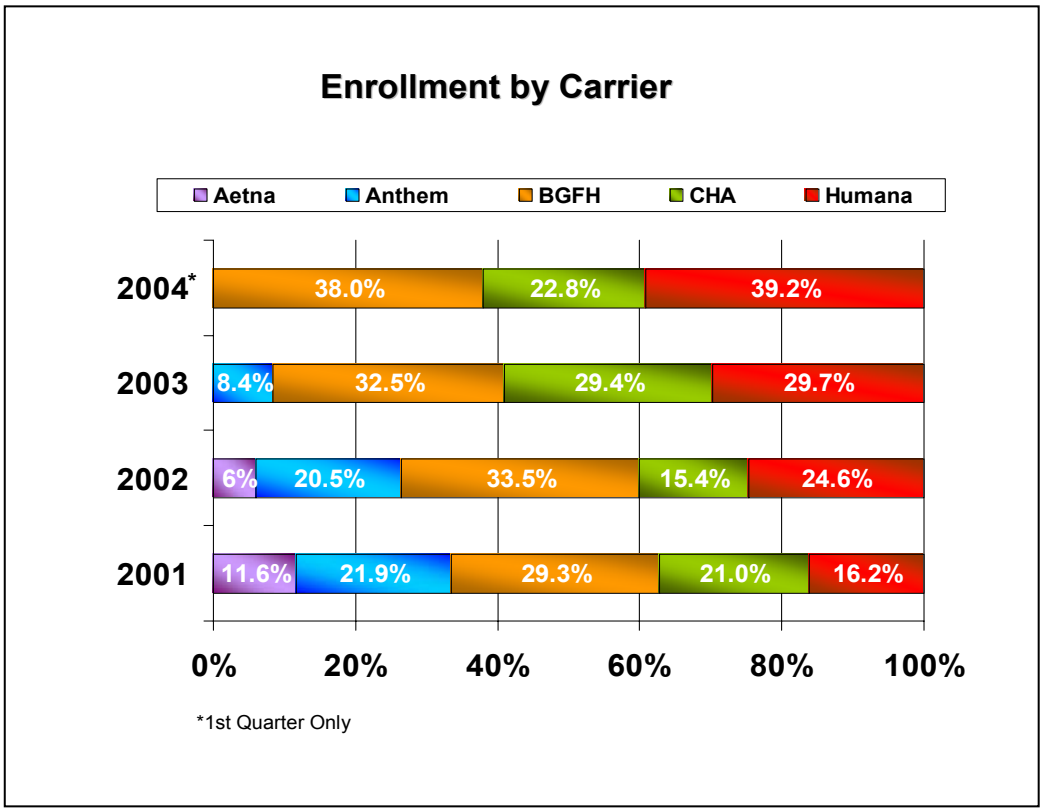
- an increase in the number of counties in which Bluegrass Family Health was offered from 58 in 2000 to 67 in 2001,
- a decline in the number of counties in which CHA was offered, and
- the demise of Advantage Care.

In 2001, CHA was offered in 59 counties, down from 78 in 2000. This was the primary cause of the decrease in CHA's enrollment percentage from roughly 25% in 2000 to 21% in 2001. Additionally, with an HMO A single premium rate that was $38.54 less per month than CHA's, Aetna's re-entrance created more competition for CHA in Northern Kentucky.

Both Anthem and Humana increased the number of counties in which they were offered in 2001. However, this did not result in an increase in either carrier's enrollment percentage in 2001. In fact, both lost enrollment in 2001, primarily due to the return of Aetna in 2001. Aetna's single HMO Option A rate was only one dollar more than the Commonwealth's contribution in the counties in which Aetna was offered. For only one dollar, individuals could purchase Single coverage in the HMO Option A through Aetna rather than receiving the Single PPO Option A at no cost. Also, the Aetna rate for HMO A Single coverage was $45.48 less monthly than Anthem's and $14.68 less than Humana's.

The chart in Exhibit VIII contrast the percentage of Commonwealth Group members enrolled in each carrier's offerings since 2001.

Exhibit VIII



Source: Commonwealth's enrollment aggregated by MedStat

In 2002, the following factors affected the Commonwealth's enrollment in each carrier's offerings:

- Aetna was discontinued in eleven counties, as it scored lower in the Commonwealth's proposal evaluation than the other three carriers that bid in those counties and its premium increases in the counties in which it remained were disproportionate to those of the other carriers insuring members of the Commonwealth group. Where single coverage under the Aetna HMO A option was less than $5 more a month than the Humana PPO A option in 2001 and less than $1 more a month than the Bluegrass Family Health PPO A option, in 2002, single coverage under the Aetna HMO A option was over $38 more a month than the Bluegrass Family Health PPO A option and $43 more a month than the Humana PPO A option.
- While Anthem expanded the counties in which it offered coverage by nineteen counties, it encountered significant competition from Humana and/or Bluegrass Family Health in eight counties. In these eight counties, Anthem's single monthly PPO Option A premium rate exceeded these two carriers' PPO Option A rate by $60 to $75.

- Bluegrass Family Health's enrollment grew primarily from its expansion into thirteen additional counties, even though it was no longer available in one county where it was offered in 2001 (as it did not meet the Commonwealth's network requirements) and withdrew from offering HMO and POS options in two other counties.
- CHA's enrollment declined as it did not bid to offer coverage in four counties where it was the only carrier offered in 2001. Additionally, CHA withdrew from offering coverage in four other counties, changed from HMO and POS options to PPO in four other counties, and failed to meet the Commonwealth's network requirements in two counties. While CHA was newly offered in eight counties (HMO and POS), its premium rates were higher than other carriers' premiums for similar offerings.
- Humana's enrollment increased as:
  - it was newly offered in nine counties, although discontinued in eight counties where its enrollment was small, and
  - its PPO and HMO options were less expansive than competing carriers in virtually every county in which Humana was offered.

In 2003, the three most significant factors that affected the Commonwealth's enrollment were:

- Aetna declined to bid, thereby exiting eighteen counties where it was offered in 2002.
- Anthem's withdrawal from sixteen counties where it offered HMO and POS options in 2002 and from 34 counties in which it offered PPO options in 2002.
- CHA offered PPO options in 50 additional counties and was the lowest cost A option in 56 counties within the Commonwealth. Additionally, CHA's HMO and POS options became available in six counties where not offered in 2002, although discontinued in four counties.

In 2004, the Commonwealth's enrollment has been impacted primarily by:

- Anthem no longer being available;
- Humana's 2% reduction in its PPO premium rates, resulting in Humana being the lowest cost A option in 99 counties within the Commonwealth; and
- Humana's decision not to offer HMO and POS options to PEHI members, other than those in six counties in northern Kentucky.

Prescription Drug Experience

Consistent with marketplace trends, the gap in the percentage increase in prescription drug expenditures under the Commonwealth's Public Employee Health Insurance Program in comparison to the percentage increase for other covered services has continued to narrow. However, the Commonwealth's 2003 prescription drug cost increase still outpaced the increase in cost for the other services covered under the Commonwealth's health insurance program.

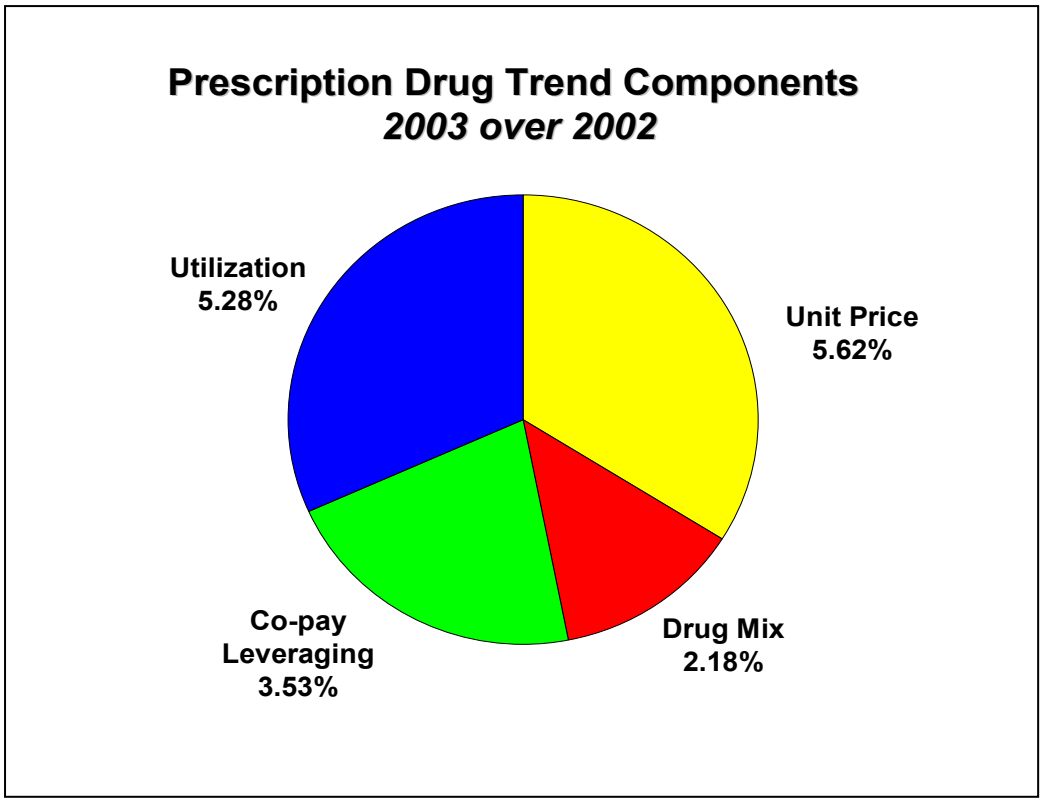
This increase is attributable to four identifiable factors:

- an increase in unit price per prescription for the same drug (*Unit Price*),
- a change in the mix of drugs received by PEHI program members (*Drug Mix*),
- co-payment leveraging – the impact of fixed dollar co-payments on the Commonwealth's health plan's cost in relation to unit price increases (*Co-pay Leveraging*), and
- an increase in the number of prescriptions received by Commonwealth Group members (*Utilization*).

Unit Price

As illustrated in Exhibit IX, unit price, as measured by comparing the price per prescription for all drugs utilized by Commonwealth Group health members, increased 5.62% from 2002 to 2003. This followed a 5.9% unit price increase in 2002. This component of the Commonwealth's prescription drug expenditure increase is limited to the pure price increase that would have resulted if covered individuals received exactly the same drugs in 2003 as were received in 2002. The increase in unit drug prices in 2001 was 5.7% and 4.1% in 2000.

Exhibit IX



Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance, compiled by MedStat and analyzed by Mercer.

Drug Mix

Over time, physicians' prescribing patterns and patients' preferences for certain prescription drugs change. This has been affected by three factors:

1) "direct-to-consumer" advertising by the pharmaceutical industry,
2) increases in the number of pharmaceutical representatives who call on physicians, and
3) an influx of new drugs into the marketplace.

To measure the impact that changes in the mix of prescriptions that PEHI members received had on the program's pharmacy costs, the average cost per prescription for 2002 was compared to 2003. After eliminating the change in pharmacy costs due to pure price increases (5.62%), the resulting increase in the cost per prescription from 2002 to 2003, due to the change in the mix of drugs received, was 2.18%, up slightly from the 2.1% increase experienced in 2002. (In 2001, the increase in prescription drug cost due to drug mix was 3.1%, with 3.5% in 2000).

Co-Pay Leveraging

When prescriptions are received from a network pharmacy, PEHI members pay a fixed dollar co-payment for each prescription. These co-payments remained the same or declined from 1999 through 2003. Due to the fact that the amount that PEHI members paid for prescriptions remained constant or declined while the cost per prescription increased, the amount paid by the Commonwealth's health plan, per prescription, has increased, each year since 1999, at a higher rate than the total cost per prescription. In 2003, the leveraging resulting from the fixed dollar prescription drug co-payments in the Commonwealth's health insurance program resulted in an increase in prescription drug costs of 3.53%. The percentage increase due to co-pay leveraging was higher in 2003 than the 3.0% experienced in 2002, the 2.3% experienced in 2001, or the 2.4% increase experienced in 2000.

Prescription Drug Utilization

The final component of the change in prescription drug expenditures in the Commonwealth's Public Employee Health Insurance Program is from the change in the number of prescriptions received by its members. The number of prescriptions covered by the Commonwealth's health plan increased 5.28% from 2002 to 2003. This was down from the increase of 6.1% from 2001 to 2002, the 7.7% increase from 2000 to 2001, and the 2000 increase of 6.8%. The average number of prescriptions per covered individual paid for by the Commonwealth's Public Employee Health Insurance Program is illustrated in Exhibit X, along with a breakdown among single source brand name drugs, multi-source brand name drugs and generic drugs.

Exhibit X

PEHI Prescription Drug Utilization

Mail Converted to Retail 3 for 1

	Average Prescriptions per Person				% Change 2002 to 2003
	2000	2001	2002	2003	
Scripts per Person	14.9	16.05	17.17	18.08	5.28%
Single Source Brand*	6.98	8.44	8.74	8.79	0.57%
Multi Source Brand*	2.00	1.16	1.17	1.17	(0.24%)
Generic*	5.68	6.20	7.00	7.79	11.36%

* excludes those not classified in one of these groups, so these categories total less than the overall scripts per person

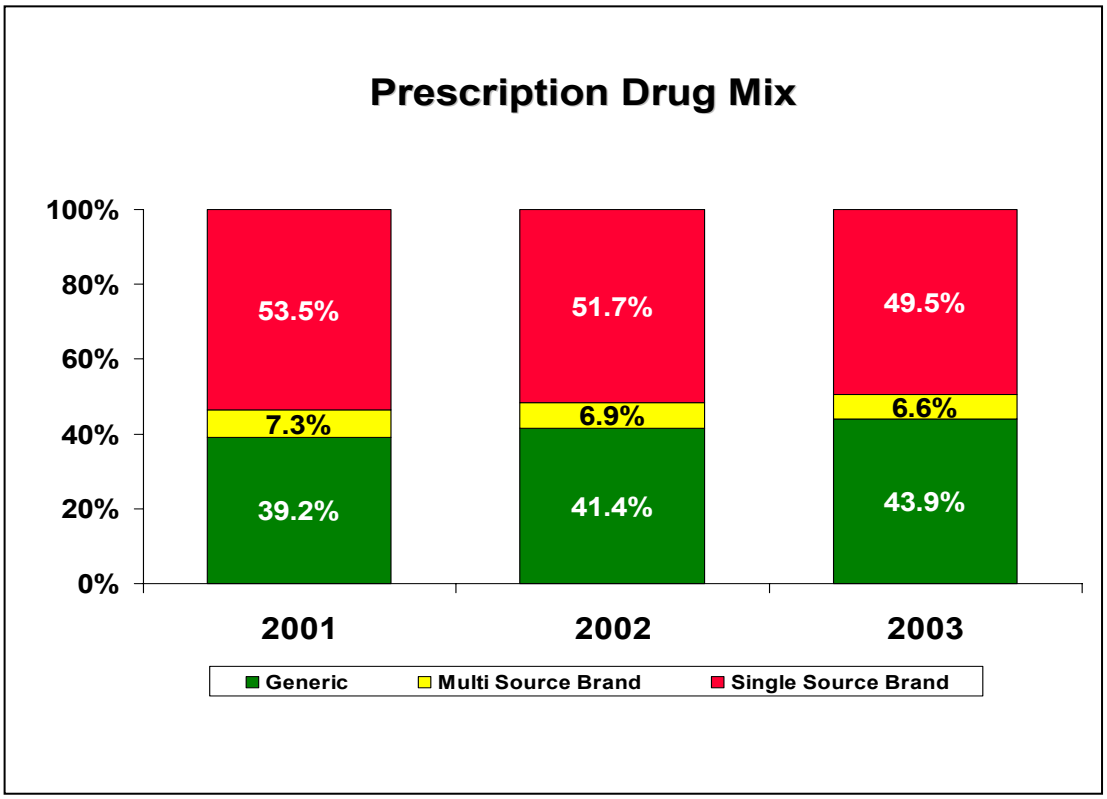
Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance, compiled by MedStat and analyzed by Mercer.

Based on the available per member per month prescription drug utilization data available since 2000:

- The number of single-source brand name drugs received by PEHI members increased at the fastest pace in 2001, 20.9%. Fortunately, this growth slowed substantially in 2002 to only 3.6% in 2002 and 0.6% in 2003.
- The number of multi-source brand prescriptions, those drugs for which an alternative generic drug is available, decreased 42% in 2001 and basically remained unchanged in 2002 and 2003.
- Generic prescriptions, the least expensive type of prescription, increased in 2001, but at a much lower rate, 9.1%, than single-source brand drugs, which have a much higher cost. In 2002, at 12.9% and 2003, at 11.3%, this type of prescription had the highest percentage increase.

As illustrated in Exhibit XI, due to the unequal increase in utilization by type of prescription, the percentage of prescriptions received by PEHI members dispensed as single source brand name drugs decreased from 53.5% in 2001 to 51.7% in 2002 and further, to 49.5% in 2003. Multi-source brand name drugs declined from 7.3% of prescriptions received in 2001 to 6.9% in 2002 and 6.6% in 2003. The generic prescription percentage has continually increased – from 38.7% in 2000 to 39.2% in 2001, to 41.4% in 2002 and 43.9% in 2003.

Exhibit XI



Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance, compiled by MedStat and analyzed by Mercer.

Summary Statistics

Summary statistics comparing:

- the allowed cost per unit – total cost per service after negotiated discounts were applied, but inclusive of members' co-payments, deductibles, co-insurance (Note: The percentage change in allowed cost reflected in Exhibit XII comprises both Unit Price and Service Mix changes);
- utilization; and
- co-pay leveraging – the increase by which the plan's net payments for a service exceeds the increase in allowed cost for that service

are provided for selected services in Exhibit XII.

Exhibit XII

Public Employee Health Insurance Program
Summary Statistics

Allowed Cost per Unit	2001	2002	2003	2002 to 2003 % Increase
Rx's (Retail and Mail)	$42.16	$45.57	$49.18	7.9%
Office Visits	$79.48	$84.55	$92.69	9.6%
Inpatient Days	$1,897	$2,036	$2,275	11.7%
ER Visits	$246	$278	$293	5.5%

Utilization	2001	2002	2003	2002 to 2003 % Increase
Rx's per Member	16.05	17.17	18.08	5.3%
Office Visits per Member	6.15	6.47	6.53	1.0%
Inpatient Days per 1000 Members	296	310	335	8.1%
ER Visits per 1000 Members	181	205	220	7.7%

Co-pay Leveraging	2001 Net Pay	2002 Net Pay	2003 Net Pay	2002 to 2003 % Increase	2002 to 2003 Leveraging % Increase
Rx's (Retail and Mail)	$28.51	$31.75	$35.48	11.7%	3.5%
Office Visits	$65.92	$70.85	$78.74	11.1%	1.4%

Source: Claims reported by the PEHI program's insurers and enrollment reported by the Department for Employee Insurance, compiled by MedStat and analyzed by Mercer.

This summary indicates that:

- The allowed cost per service increased measurably for inpatient hospital days, physician office visits and prescription drugs, and to a lesser extent, emergency room visits.
- Inpatient hospital days per 1000 PEHI members increased significantly from 2002 to 2003 (8.1%) as did emergency room visits (7.7%). The increase in inpatient hospital days was up from the 2002 increase of 4.7%. The 2003 increase in emergency room visits compounded the dramatic 2002 increase of 13.3%.
- Prescription drug utilization continued to increase in 2003, but at a lower rate than inpatient days or emergency room visits.
- Visits to physicians' offices increased only slightly in 2003 (1%) following a steeper increase in 2002 (5.2%).
- As fixed dollar co-payments for prescription drugs and physician office visits have not changed since 1999, in both 2002 and 2003 the PEHI program experienced per unit cost increases for these services that exceeded the level of total allowed cost increases (plan's payment plus member cost-sharing) for these same services.

Findings

Key trends for the 2003 plan year, are:

- The Commonwealth's 2003 premium increase of 10.6% compares to the aggregate cost increases reported by employers that participated in Mercer's *National Survey of Employer-Sponsored Health Plans for 2003* as follows:
  - 10.2% nationally for employers in all industry groups with 500 or more employees,
  - 11.3% for state government employers, and
  - 6.5% for employers located in the South (U.S. census region) with 500 or more employees.
- While the gap between the percentage increase in prescription drug expenditures (17.7%) and the percentage increase in other covered expenses in the Commonwealth's program (13.5%) become even narrower in 2003, the increase in prescription drug expenditures still outpaced the increase in other covered expenses.
- Payments for the medical supplies and services received by PEHI members have increased at a faster pace than premiums paid to the Commonwealth's health insurance carriers. Therefore, the plan's overall loss ratio increased from 91.9% in 2002 to 95.1% in 2003. In 2003, a greater share of the Commonwealth's and PEHI members' premium payments went to pay healthcare providers than in any previous year, leaving a smaller percentage of premium dollars to pay the insurers' operating expenses and contribute to their profits. In fact, the total dollars retained by the Commonwealth's insurers declined from roughly $51 million in 2002 to about $34 million in 2003 (about $20 per employee/retiree per month).
- While the number of employees and retirees insured under the Commonwealth's health insurance program increased roughly 2% in 2003, due to a decline in the number of individuals electing dependent healthcare coverage, the number of covered lives increased only slightly from 2002. The percentage of individuals electing dependent health insurance in the Commonwealth's program continues to decline, likely as a result of the Commonwealth's contribution policy and the aging of employees and retirees covered under the program.
- The number of active employees, excluding covered dependents, insured under the Commonwealth's health insurance program did not increase from 2002 to 2003. However, the number of covered retirees, excluding covered dependents, increased, on average, by almost 2,600. Retirees and their covered dependents comprised 14.3% of all insured PEHI members in 1999. This grew to 20.1% by the first quarter of 2004. This trend has long-term cost implications for the Public Employee Health Insurance Program, due to the impact of aging on healthcare consumption.
- While aggregate HMO enrollment (option A and B) remained relatively steady at around 50% of the enrolled population in 2002, there was a shift from Option A to Option B. In 2003, there was a further shift from Option A to Option B **and** a substantial decline in aggregate HMO enrollment to about 44% of the enrolled population. In 2004, this decline was exacerbated by Humana's decision to only offer HMO and POS options to PEHI members in six counties. In 2004, HMO enrollment is only about 33% of total enrollment. Point of Service (POS) enrollment continues to decline dramatically, from 33% in 1999 to less than 6% in 2004. PPO enrollment grew from roughly 20% in 2000 to over 60% in the first quarter of 2004, with the majority of this increase occurring in PPO Option A.

Enrollment grew in this option from 14.3% in 1999 to 57.4% in 2004. Enrollment in the Exclusive Provider Option, implemented by the Commonwealth January 1, 2000, has remained relatively steady.

- Enrollment among the Commonwealth's insurance carriers has shifted over the years in response to carriers' offerings and their pricing policies. However, by 2003, the majority of the Commonwealth's enrollment was concentrated in three carriers' offerings - Humana (30%), Bluegrass Family Health (33%) and CHA (29%). Anthem's enrollment declined to only about 8% of the group by 2003, due to its decision to only offer PPO options in a limited number of counties. In 2004, Anthem is not available and no carriers were added. This resulted in 38% - 40% of enrollment in each of Humana and Bluegrass Family Health and around 23% in CHA as of the first quarter of 2004.
- The 2003 per capita increase in prescription drug expenditures in the Public Employee Health Insurance Program of 17.7% was higher than reported by participants in Mercer's *National Survey of Employer-Sponsored Health Plans for 2003.* Survey respondents reported aggregate prescription drug costs increases of:
  - 16.1% nationally for employers in all industry groups with 500 or more employees,
  - 14.8% for state government employers, and
  - 16.6% for employers located in the South (U.S. census region) with 500 or more employees.

  Note: As noted in the October 2002 and 2003 report, the increases reported by survey respondents reflect the net increase in cost after taking into account the increases in prescription drug cost sharing implemented by some survey respondents. The Commonwealth's prescription drug co-payments have remained the same, while some survey participants' cost-sharing has increased, at least partly explaining why the Commonwealth's prescription drug expenditures rose at a faster pace than the market.

  Based on data reported by the Commonwealth's insurance carriers and aggregated by MedStat, the Commonwealth's prescription drug increase is attributable to four quantifiable factors:
  - an increase in unit price per prescription for the same drug – accounted for a 5.62% increase in prescription drug costs,
  - a change in the mix of drugs received by PEHI members – accounted for a 2.18% increase in prescription drug costs,
  - co-payment leveraging, the impact of fixed dollar co-payments on the Commonwealth's health plan's cost in relation to unit price increases – which accounted for an increase of 3.53%, and
  - utilization – an increase of 5.28%.

Conclusions

- Based on its historical experience and increasing percentage composition of retirees, the Commonwealth's health insurance costs are expected to continue to increase at levels well in excess of general inflation for the foreseeable future.

- Without a change in the Commonwealth's contribution policy – paying the full cost of single coverage for the lowest cost A option available in each county with no subsidy for dependent premiums – it is anticipated that the percentage of Public Employee Health Insurance Program members enrolling their dependents will continue to decline, as it has continually since 1999.

- Participation in a pharmacy benefit purchasing cooperative could lower the Commonwealth's prescription drug costs by 3% to 10% and provide more consistent pharmacy benefit administration (formularies, step-therapy, quantity limits, etc.) to members of the Public Employee Health Insurance Program. However, from a practical perspective, participation in a pharmacy benefit purchasing cooperative will only be an option for the Commonwealth if it decides to self-fund its health insurance benefits at some point in the future.

- With claims increases outpacing premium increases since 2001, the Commonwealth and its members should anticipate significant premium increases in 2005, unless program changes are implemented.

Market Comparison

The October 2001 Board report included a comprehensive comparison of the Commonwealth's Public Employee Health Insurance Program to that of other states. In the October 2003 report, this report section reflected a comparison of the Commonwealth's 2002 health plan provisions to the results of Mercer Human Resource Consulting's 2002 *National Survey of Employer-Sponsored Health Plans*. These comparisons have been omitted from this year's report, as some Board members feel that it is important for the Commonwealth to view its health insurance benefits in the context of its total compensation program. In this context, these Board members generally believe that the Commonwealth's health benefit plan provisions must be above the median of the market to attract and retain qualified employees.

Consumer Information and Education

In an efficiently functioning market, consumers can make informed choices among alternative options based on their individual assessment of value and price. Consumers have access to information about the products and services available, can evaluate product value and risk, and can choose among products with varying quality attributes at different prices. They must also bear the financial burden for their decisions.

In theory, consumers' choices influence the market's production of various products and services and the prices at which these products and services are offered. Consumer buying power, in an efficient market, is also credited with encouraging product innovation and quality enhancements.

The Need for Health Care Price and Quality Information

In practice, most consumers of health care, like members of the PEHI program, have little access to information about health care services, products, prices, quality, or relative value. They do not know what different providers charge, nor which provider offers the best value. The relative merits of health care programs are not widely published, and most consumers are more likely to select a provider based on reputation, physician referral, and family recommendations than on price, quality or performance.

Furthermore, the insured consumer's choices about which doctor to use, when to seek care, and how to manage his or her health, have had relatively little impact on his or her direct out-of-pocket expenses. Although PEHI members contribute something to the cost of their care, for the most part, this contribution has been through dependent health insurance premiums and/or flat co-pay amounts, obligations that contribute little to their understanding of, or sensitivity to, service pricing or value. And critically, often neither the consumer nor the physician recommending treatment has any advance knowledge of the cost of treatment or the relative value of alternative options.

Healthcare Provider Quality Variation

According to an article published in the August 2, 2004 edition of *Newsweek*, in 1999, the Institute of Medicine announced that as many as 98,000 Americans die every year from medical errors. Shocking as that may have seemed, it now appears that this estimate may have been low. A new study issued by HealthGrades at the beginning of August 2004, found that needless deaths averaged 195,000 a year in 2000 through 2002. "That's the equivalent of 390 jumbo jets full of people dying each year," says Dr. Samantha Collier, vice president of medical affairs.

While it would seem that all, or at least most, doctors follow accepted procedures, a 2003 Rand Corp. study said that Americans get the right treatment only half the time.

In Exhibit XIII, 2003 quality of care indicators, as defined by MedStat, for the Public Employee Health Insurance program are summarized.

Exhibit XIII

2003 PEHI Quality of Care Indicators

	Per 1000	Net Payments
Avoidable Admits	9.78	$15,015,366
Readmits	4.48	$11,388,736
Complications of Previous Treatment	12.72	$22,872,035

Source: *MedStat database with claims paid through June 2004*

Note: Avoidable Admits – inpatient admit for angina w/o procedure, asthma, bacterial pneumonia, CHF, COPD, dehydration, diabetes, hypertension, low birth weight, pediatric gastroenteritis, perforated appendix, and urinary tract infection

Readmits – acute admission within 15 days of a previous admission

Summary

As more financial responsibility is placed on PEHI members when they consume health care services, the Board believes that the Commonwealth should investigate ways to promote PEHI members' access to:

- provider quality information;
- provider cost data; and
- the cost and relative value of alternative health services and prescription drugs.

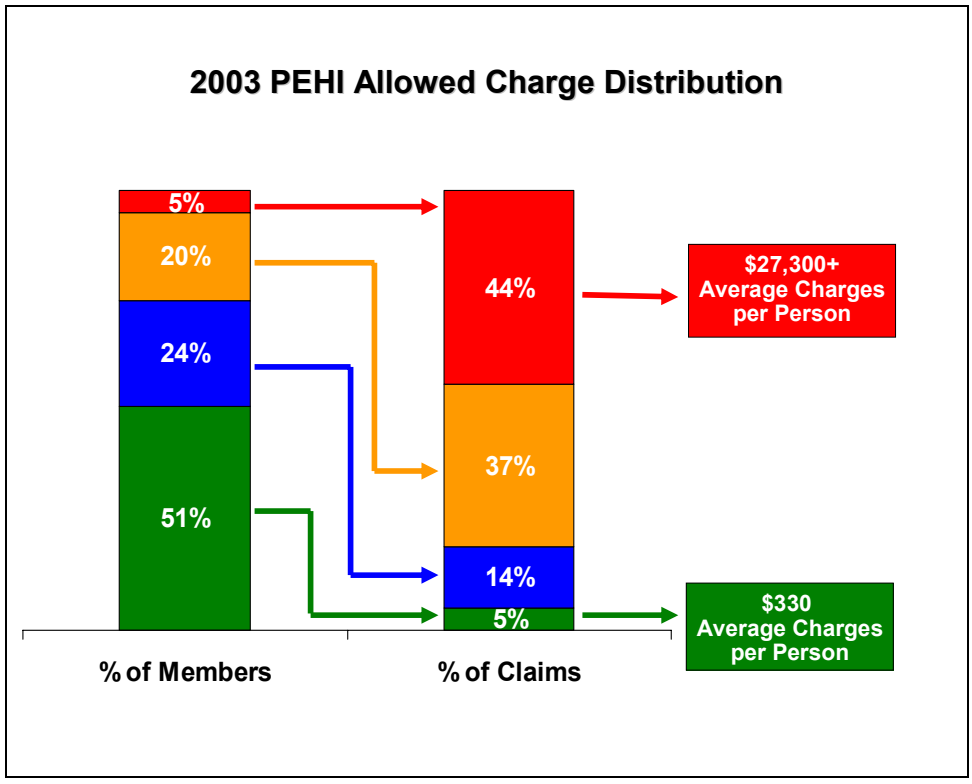
Coupled with the information outlined, the Board recommends that the Commonwealth implement initiatives to educate PEHI members on how to make informed health care decisions. These should include decision support services that provide comparative information that enables PEHI members to choose wisely from among alternative plans, providers, treatment options, and level of care.

Health Promotion and Disease Management

The experience of the Public Employee Health Insurance program is similar to that of other employer-sponsored health plans, in that, a small number of individuals account for a substantial portion of the program's claims. As illustrated in Exhibit XIV, in calendar 2003:

- 5% of the individuals covered by the PEHI program accounted for 44% of the total allowed charges of all PEHI members. The average allowed charges per person for these individuals was over $27,300 in 2003.
- Another 20% of covered individuals were responsible for 37% of the total allowed charges of PEHI members.
- At the bottom of the chart, the 51% of covered individuals with the lowest healthcare costs only generated 5% of the program's allowed charges.
- Over 75% of the individuals covered by the PEHI program had covered healthcare expenses in 2003 that were below the average of the entire PEHI group.

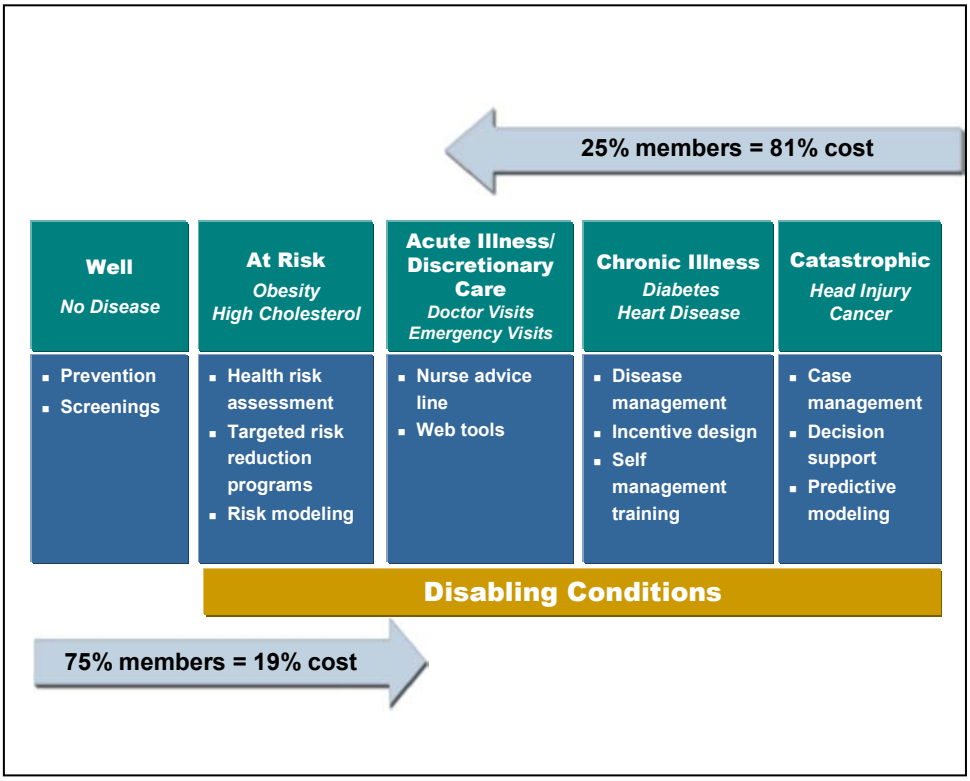
Exhibit XIV



Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance, complied by MedStat and analyzed by Mercer

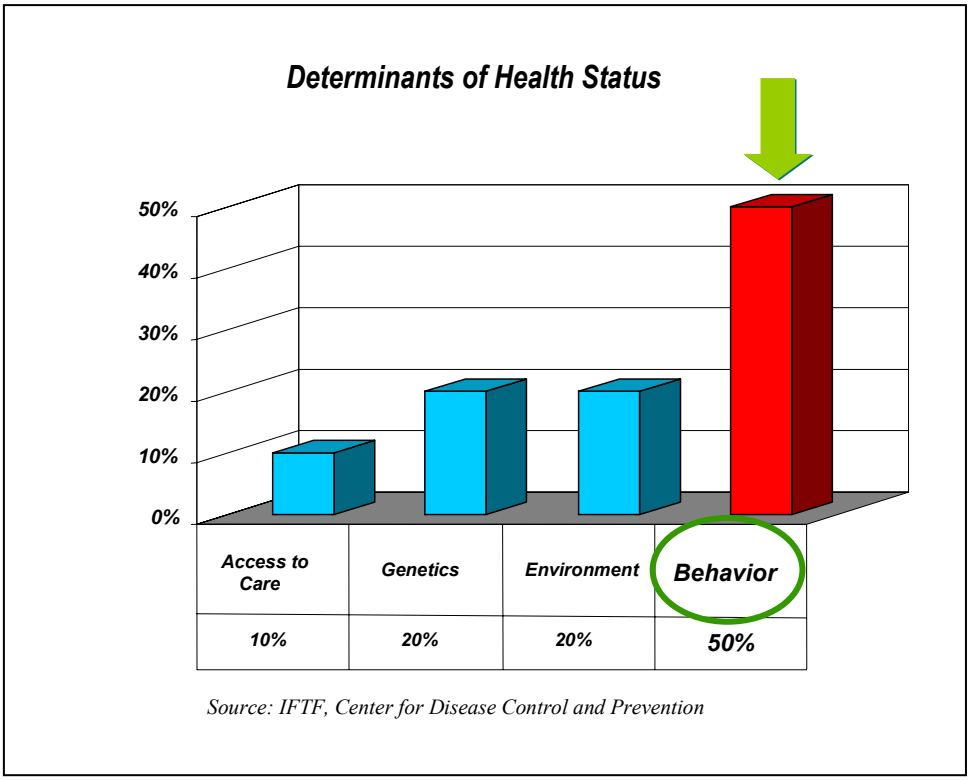
Due to the wide diversity in the health status of individuals that participate in the PEHI program, it is important that health promotion and health management efforts are broad-based to cover the entire spectrum of the population. Graphically, these efforts might be summarized as shown in Exhibit XV.

Exhibit XV



Research shows that behavior is a far more significant driver of health status than environment, genetics or access to health care. In fact, its impact is as powerful as all three of these other factors combined. (See Exhibit XVI.) Poor health status and inappropriate use of health care services are outcomes that can be changed through behavior modification. However, consumers have to be informed and engaged for this to occur.

Exhibit XVI



Source: IFTF, Center for Disease Control and Prevention

The health status of Kentuckians overall does not compare favorably to other states. In the 2003 edition of *America's Health, State Health Rankings,* Kentucky ranked:

- 49th with respect to Prevalence of Smoking
- 43rd for Risk of Heart Disease, and
- 50th for Cancer Deaths.

With the health status of Kentuckians overall as a backdrop, it is not surprising that the prevalence of several chronic diseases within the Public Employee Health Insurance program's membership is higher than MedStat-provided age and gender adjusted benchmarks, as summarized in Exhibit XVII.

Exhibit XVII

2003 Chronic Condition Prevalence in PEHI Program
Compared to Benchmarks

Patients per 1000	PEHI 2003	U.S. Total		State and Local Governments		South Region	
		Bench-mark	% Diff	Bench-mark	% Diff	Bench-mark	% Diff
Osteoarthritis	61.52	52.68	16.8%	51.68	19.1%	50.37	22.1%
COPD	16.71	14.87	12.4%	14.37	16.2%	13.83	20.8%
Hypertension	166.89	128.87	29.5%	144.86	15.2%	145.24	14.9%
Asthma	34.18	33.44	2.2%	29.76	14.9%	27.97	22.2%
Coronary Artery Disease	32.82	31.40	4.5%	28.90	13.6%	28.84	13.8%
Diabetes	61.90	57.11	8.4%	58.64	5.6%	58.56	5.7%
Rheumatoid Arthritis	5.98	6.01	-0.5%	5.67	5.4%	5.54	7.8%
HIV Infection	0.49	0.85	-42.9%	1.16	-58.1%	0.93	-47.7%

Source: *MedStat database with claims paid through June 2004*
Benchmarks are from MedStat and reflect 2003 age/gender adjusted norms

Note: The Commonwealth's MedStat data excludes most mental health/substance abuse claims, so anxiety disorders, bipolar disorder and depression have been eliminated from this analysis

The high prevalence of chronic conditions in the PEHI program has a significant impact on the program's cost. However, for some conditions, particularly, Chronic Obstructive Pulmonary Disease (COPD) and Coronary Artery Disease, PEHI emergency room usage, as compiled by MedStat from data reported the PEHI program's insurers for 2003, far exceeds benchmarks, even if these benchmarks were adjusted for the higher prevalence of these conditions within the PEHI membership. (See Exhibit XVIII.) This, in combination with the inpatient hospital statistics provided in Exhibit XVIV, suggests that PEHI members could benefit from outreach programs to assist them in understanding how to manage their health in view of their chronic health conditions.

Exhibit XVIII

PEHI Chronic Conditions – 2003 Emergency Room Usage

Emergency Room Visits per 1000	PEHI 2003	U.S. Total Benchmark	% Difference
Osteoarthritis	0.44	0.17	155.4%
COPD	***1.05***	***0.20***	***415.3%***
Hypertension	1.60	0.64	148.9%
Asthma	2.88	1.19	142.1%
Coronary Artery Disease	***3.24***	***0.44***	***634.2%***
Diabetes	1.25	0.56	122.2%
Rheumatoid Arthritis	0.05	0.03	44.9%
Asthma	2.88	1.19	142.1%
All Conditions	***221.46***	***87.44***	***153.3%***

Source: *MedStat database with claims paid through June 2004*
Benchmarks are from MedStat and reflect 2003 age/gender adjusted norms

Note: *The Commonwealth's MedStat data excludes most mental health/substance abuse claims, so anxiety disorders, bipolar disorder and depression have been eliminated from this analysis*

Exhibit XIX

PEHI Chronic Conditions – 2003 Inpatient Usage

	Admissions per 1000			Days Length of Stay		
	PEHI 2003	U.S. Total Benchmark	% Difference	PEHI 2003	U.S. Total Benchmark	% Difference
Osteoarthritis	1.97	2.24	-12.2%	3.77	3.62	4.2%
COPD	1.07	0.63	69.2%	4.61	4.84	-4.8%
Hypertension	0.67	0.46	44.5%	3.59	4.36	-17.6%
Asthma	0.93	0.78	18.2%	3.53	3.25	8.7%
Coronary Artery Disease	5.27	4.45	18.3%	3.52	3.51	0.3%
Diabetes	0.93	0.84	11.5%	5.24	4.77	9.9%
Rheumatoid Arthritis	0.05	0.06	-18.5%	5.09	4.18	21.8%
HIV Infection	0.01	0.04	-80.0%	11.5	10.4	10.6%
All Conditions	***85.16***	***78.76***	***8.1%***	***3.97***	***4.66***	***-14.9***

Source: *MedStat database with claims paid through June 2004*
Benchmarks are from MedStat. Admissions per 1000 reflect 2003 age/gender adjusted norms. Days LOS are not adjusted.

Note: *The Commonwealth's MedStat data excludes most mental health/substance abuse claims, so anxiety disorders, bipolar disorder and depression have been eliminated from this analysis*

Summary

There is wide diversity in health status among PEHI members and a high prevalence of chronic health conditions. Therefore, the Board recommends that:

- The Commonwealth implement initiatives to educate PEHI members on:
  - the positive impact of healthy lifestyle choices;
  - how to best manage their chronic health conditions; and
  - how to make informed health care decisions.
- The Commonwealth actively promote initiatives that support healthy lifestyle behaviors.

Unescorted Retirees

Individuals who participate in a state sponsored retirement program are eligible to participate in the Public Employee Health Insurance program. These retirees include not only former employees of state agencies and school districts, but also former employees of cities, counties, and municipalities that participate in the County Employees Retirement System (CERS) and former employees of regional universities. Health insurance coverage for the pre-65 retirees of the Commonwealth's KTRS, KERS, SPRS and CERS programs is provided through the same program that covers active state employees. However, active employees of the Commonwealth's regional universities do not participate in the Public Employee Health Insurance program, neither do active employees of most of the cities, counties and municipalities that participate in the CERS program. Rather, these entities maintain separate health insurance programs for their active employees. In prior discussions, the term, "unescorted retirees" has been assigned to this group of retirees.

The Public Employee Health Insurance program's costs are negatively impacted by the fact that the retirees of CERS and regional universities participate in the Commonwealth's healthcare program, while the active employees of these employers do not. In the Board's October 2002 report, supported by an independent analysis conducted by The Segal Company at the request of the Interim Joint Committee on State Government, it was estimated that these "unescorted" retirees added between $14 and $16 million in excess claims to the Public Employee Health Insurance Program in 2001. As illustrated in Exhibit XX, by calendar year 2003, this additional claims cost (Plan Payments in the following exhibit) grew to about $21 million. This equates to PEHI program costs that were about 3.3% higher than they otherwise would have been.

Exhibit XX

	Calendar 2003 PEHI Program		
	Unescorted Retirees	All Other PEHI Members	Difference
Average Allowed Charges Per Member Per Month	**$422.28**	**$272.22**	**$150.06**
Average Plan Payments Per Member Per Month	**$363.08**	**$233.07**	**$130.01**
# of Members	**13,385**	**213,014**	
Additional Annual Allowed Charges			**$24,101,559**
Additional Annual Plan Payments			**$20,880,964**
% Increase in Total Cost			**3.3%**

Note: The average monthly figures reflected in the table above, include expenses for covered dependents. Allowed Charges reflect the total amount paid to healthcare providers by the PEHI program and its members (through their deductibles, co-payments, etc. for covered services), after taking into account negotiated provider discounts. Plan Payments represent only the amounts paid by the PEHI program, exclusive of members' deductibles, copayments and coinsurance.

Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance, compiled by MedStat and analyzed by Mercer.

Conclusions

Currently, the inclusion of "unescorted retirees" in the Public Employee Health Insurance program increases the program's average cost, and therefore its premium rates. The additional cost resulting from including these individuals and their covered dependents in the PEHI program grew from $14 to $16 million in calendar 2001 to almost $21 million in calendar 2003. In 2003, this additional cost equated to a 3.3% increase in the program's average cost.

Healthcare Flexible Spending Accounts for Those Waiving Health Insurance

In calendar 2004, there are close to 33,000 active employees who are eligible for coverage under the Public Employee Health Insurance Program, yet waive this coverage. In lieu of health insurance, these individuals receive a monthly employer contribution of $234 into a healthcare flexible spending account (FSA). This healthcare FSA contribution for 2004 for all PEHI groups is estimated to be roughly $92 million, before taking into account any forfeitures recouped from individuals who don't utilize all of the funds available. This represents about 15% of estimated total employer health insurance expenditures.

This feature of the Commonwealth's program is much more generous than that of most employers.

- In the Commonwealth's 2001 survey of other states, to which 36 states responded, only 4 (10%) provided an alternative benefit to individuals who waived health insurance. Of these, the alternative benefit ranged from a monthly healthcare FSA contribution of $25 to a maximum of $128 monthly in flex credits.
- In a 2002 survey of large, private sector Kentucky employers, 25% offered an alternative benefit to employees who waived health insurance. For these employers, the alternative benefit ranged from $50 to $75 per month.

For calendar 2005, it is the Board's understanding that the Commonwealth will reduce the contribution it makes to a healthcare FSA for those waiving health insurance to $100 per month. Irrespective of how the Commonwealth's policy in this regard compares to the market, the Board is concerned about the impact that this planned change may have on some employees. Anecdotally, some Board members have heard that, due to the magnitude of health insurance premium contributions required of employees electing dependent health insurance, some employees currently waive health insurance through the PEHI program and utilize the FSA funding provided by the Commonwealth to cover up to $2,808 of their family's health care expenses annually.

Currently, the Commonwealth does not have information with respect to whether those employees who waive health insurance through the PEHI program have other health insurance coverage. Therefore, the prevalence of employees waiving health insurance coverage through the PEHI program who have no other health insurance is not known.

The Board recommends that the Commonwealth analyze the impact of the 2005 healthcare FSA funding reduction for those waiving PEHI coverage, due to concerns that some employees have historically used this funding as their sole health care coverage.

Health Reimbursement Arrangements (HRA's) and Health Savings Accounts (HSA's)

Health Reimbursement Arrangements (HRA's)

HJR 207 and SJR 111 required the Board, in conjunction with the Personnel Cabinet, to conduct a study to determine if a health reimbursement arrangement would provide a benefit to employees and reduce employer costs for health insurance.

As neither of these resolutions provided a definition for *health reimbursement arrangement*, the Board studied two versions of these arrangements of which it was aware in the marketplace:

- as a component of an account-based consumer-directed health plan (CDHP), and
- as a mechanism to lower employer-paid health insurance expenses, by maximizing the tax advantage afforded to employer-sponsored health plans under the federal tax code.

Both of these variations include an account that, in many ways operates similarly to the healthcare flexible spending accounts (FSA's) that the Commonwealth makes available to its employees. Both HRA's and FSA's provide tax-free reimbursement for qualified medical expenses, for which an individual does not receive reimbursement from another tax-favored plan. The differences between these two types of accounts are summarized in the table in Exhibit XXI.

Exhibit XXI

	Healthcare Flexible Spending Account (FSA)	Health Reimbursement Account (HRA)
Contributions	Employer, employee, or both	Employer only
Contribution Availability	Full amount must be available first day coverage is in effect	Employer can decide – typically full amount available first day coverage is in effect
Qualifying Expenses	Miscellaneous IRC 213(d) expenses, no health premium reimbursements *Subject to employer's design*	Miscellaneous IRC 213(d) expenses, unlimited health premium reimbursements *Subject to employer's design*
Carryover of Unused Funds	Not allowed	Allowed, although employer can establish limits

Health Reimbursement Arrangements as a Component of an Account-based Consumer-Directed Health Plan (CDHP)

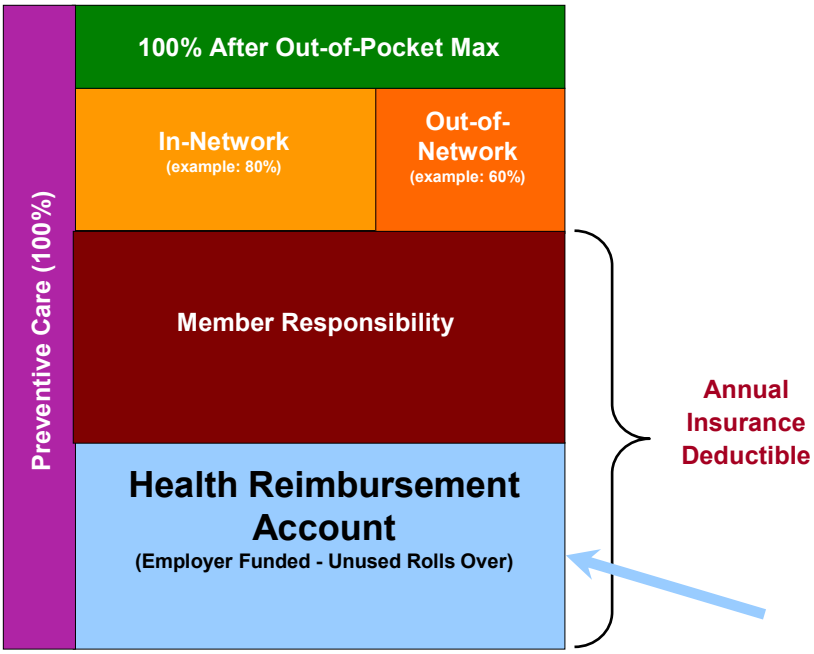
The most prevalent use of HRA's in the marketplace currently is as a component of an account-based consumer-directed health plan (CDHP). As illustrated by the chart in Exhibit XXII, the typical account-based CDHP has the following components:

- **Preventive Care** - coverage at 100 percent for covered preventive services, such as physician examinations and vaccinations received from network physicians, up to a specified dollar amount for each covered person each plan year. These expenses are not usually counted against the member's Health Reimbursement Account or applied towards the annual deductible or out-of-pocket maximum.

- **Health Reimbursement Account** – Individuals who enroll in the CDHP option receive an employer-provided allowance that can be used to pay for eligible medical expenses, other than preventive services, and perhaps prescription drugs. When a covered person receives eligible medical services, the full cost is paid from his/her Health Reimbursement Account, and applied to his/her annual deductible. If a covered person does not use the full amount of his/her Health Reimbursement Account in a year, some, or all, of the unused portion is carried over and added to his/her account for the following year, as long as he/she remains in the CDHP option. The annual allowance may be pro-rated for individuals who join the CDHP option after the beginning of a plan year.

Exhibit XXII

Account-Based Consumer-Directed Health Plan (CDHP)



- **PPO Medical Benefits –** For significant medical expenses, CDHP options provide additional coverage. This coverage works in a manner similar to the Commonwealth's PPO options. This coverage includes:
  - an **Annual Deductible**
  - **Network-based Co-insurance** and
  - an **Annual Out-of-pocket Maximum**.

The key differences are:

- members have the Health Reimbursement Account to pay for some of their medical expenses at 100%, with payments from this account applied toward the plan's annual deductible and out-of-pocket maximum; and
- typically, the annual deductible and out-of-pocket maximum are significantly higher than those in the Commonwealth's PPO A option.

- **Annual Deductible –** Once the full amount in a member's Health Reimbursement Account has been used, the member is responsible for any amount remaining of the plan's Annual Deductible. Covered medical expenses paid from the Health Reimbursement Account usually count toward meeting the Annual Deductible. (In the chart, the section labeled "Member Responsibility" is the amount by which the Annual Deductible exceeds the member's Health Reimbursement Account.)

- **Network-based Co-insurance –** Once the member meets his/her annual deductible, PPO medical benefits apply to covered medical services. The plan provides coverage for eligible services received from both in-network and non-network providers. The plan pays a higher percentage of the cost of covered services received from network providers than it does for those received from non-network providers. Additionally, the balance billing protection afforded when services are received from network providers does not apply to services received from providers that are not in the plan's network.

- **Annual Out-of-pocket Maximum –** If the combination of the annual deductible and co-insurance payments for covered services reaches the annual out-of-pocket maximum, the CDHP option pays 100% of eligible medical expenses for the rest of the plan year, subject to the plan's lifetime benefit maximum, if any. Covered medical expenses paid from the Health Reimbursement Account count toward meeting the annual out-of-pocket maximum.

Prescription drugs may be covered in the same manner as other medical services – paid at 100% from the Health Reimbursement Account until exhausted, then subject to the remaining amount of the Annual Deductible before Network-based Co-insurance applies, and capped by the CDHP option's Annual Out-of-Pocket maximum. Alternatively, coverage of prescription drugs may be carved out, like preventive care services, with a different set of benefit provisions.

Health Reimbursement Arrangements Structured to Lower Employer Health Costs by Maximizing the Tax Advantage Afforded to Employer-sponsored Health Plans

It is the Board's understanding that some entities have considered using a health reimbursement arrangement to lower employer health costs by maximizing the tax advantages afforded to employer-sponsored health plans under the federal tax code. Under this approach:

- A portion of healthcare premiums previously paid by the employer are deducted on a pre-tax basis from employees' pay.
- Employees have less taxable income, so fewer tax dollars are withheld.
- The employer contributes enough tax-free dollars to an HRA for anticipated out-of-pocket medical expenses (deductibles, co-payments, vision, dental, over-the-counter drugs, etc.) so that employees end up with virtually the same take-home pay – if their tax liability is consistent with the employer's assumptions and the employee has eligible healthcare expenses equal to or greater than the employer's HRA contribution.
- The employer saves money by paying lower Medicare and Social Security taxes and by reducing the amount it pays for employees' healthcare benefits.

The following examples reflect the Board's understanding of how an employee's pay might be affected by this type of arrangement. All of the examples assume that the employer increases employees' health insurance premiums by $100 per month and funds $73 a month in a Health Reimbursement Account (HRA). All examples are illustrative; actual taxable income and taxes would vary based on each employee's tax situation.

Example 1: No Current Healthcare FSA; Healthcare Expenses = HRA Contribution

In the following example, the employee does not currently participate in a healthcare flexible spending account. Additionally, it is assumed that the employee's qualified healthcare expenses equal the employer's HRA contribution.

		Employee's Monthly Income and Taxes		
		Current	with HRA	Change
	Gross Income	$3,300.00	$3,300.00	
-	Health Insurance Premium	$0.00	$100.00	$100.00
-	Healthcare FSA	$0.00	$0.00	$0.00
=	Taxable Income	$3,300.00	$3,200.00	($100.00)
-	Federal Taxes	$495.00	$480.00	($15.00)
-	FICA Taxes	$252.45	$244.80	($7.65)
-	State Taxes	$132.00	$128.00	($4.00)
-	Local Taxes	$33.00	$32.00	($1.00)
=	Net Income	$2,387.55	$2,315.20	($72.35)
+	Eligible Healthcare Expenses		$73.00	$73.00
=	Net Income	$2,387.55	$2,388.20	$0.65
	HRA Deposit		$73.00	
	HRA Eligible Expenses		$73.00	
	HRA Balance		$0.00	

Example 2: No Current Healthcare FSA; Healthcare Expenses < HRA Contribution

In the following example, the employee does not currently participate in a healthcare flexible spending account. Additionally, it is assumed that the employee's qualified healthcare expenses are less than the employer's HRA contribution.

		Employee's Monthly Income and Taxes		
		Current	with HRA	Change
	Gross Income	$3,300.00	$3,300.00	
-	Health Insurance Premium	$0.00	$100.00	$100.00
-	Healthcare FSA	$0.00	$0.00	$0.00
=	Taxable Income	$3,300.00	$3,200.00	($100.00)
-	Federal Taxes	$495.00	$480.00	($15.00)
-	FICA Taxes	$252.45	$244.80	($7.65)
-	State Taxes	$132.00	$128.00	($4.00)
-	Local Taxes	$33.00	$32.00	($1.00)
=	Net Income	$2,387.55	$2,315.20	($72.35)
+	Eligible Healthcare Expenses		$50.00	$50.00
=	Net Income	$2,387.55	$2,365.20	($22.35)
	HRA Deposit		$73.00	
	HRA Eligible Expenses		$50.00	
	HRA Balance		$23.00	

Example 3: No Current Healthcare FSA; No Qualified Healthcare Expenses

In this example, the employee does not currently participate in a healthcare flexible spending account. Additionally, it is assumed that the employee has no qualified healthcare expenses.

		Employee's Monthly Income and Taxes		
		Current	with HRA	Change
	Gross Income	$3,300.00	$3,300.00	
-	Health Insurance Premium	$0.00	$100.00	$100.00
-	Healthcare FSA	$0.00	$0.00	$0.00
=	Taxable Income	$3,300.00	$3,200.00	($100.00)
-	Federal Taxes	$495.00	$480.00	($15.00)
-	FICA Taxes	$252.45	$244.80	($7.65)
-	State Taxes	$132.00	$128.00	($4.00)
-	Local Taxes	$33.00	$32.00	($1.00)
=	Net Income	$2,387.55	$2,315.20	($72.35)
+	Eligible Healthcare Expenses		$0.00	$0.00
=	Net Income	$2,387.55	$2,315.20	($72.35)
	HRA Deposit		$73.00	
	HRA Eligible Expenses		$ 0.00	
	HRA Balance		$73.00	

Example 4: Current Healthcare FSA; Healthcare Expenses = FSA Contribution

In this example, the employee currently participates in a healthcare flexible spending account. Additionally, it is assumed that the employee's qualified healthcare expenses equal his/her current FSA contribution and therefore, the employee discontinues his/her FSA contribution when the employer implements the health reimbursement arrangement.

		Employee's Monthly Income and Taxes		
		Current	with HRA	Change
	Gross Income	$3,300.00	$3,300.00	
-	Health Insurance Premium	$0.00	$100.00	$100.00
-	Healthcare FSA	$70.00	$0.00	($70.00)
=	Taxable Income	$3,230.00	$3,200.00	($30.00)
-	Federal Taxes	$484.50	$480.00	($4.50)
-	FICA Taxes	$247.10	$244.80	($2.30)
-	State Taxes	$129.20	$128.00	($1.20)
-	Local Taxes	$32.30	$32.00	($0.30)
=	Net Income	$2,336.91	$2,315.20	($21.70)
+	Eligible Healthcare Expenses	$70.00	$70.00	$0.00
=	Net Income	$2,406.91	$2,385.20	($21.70)
	HRA Deposit		$73.00	
	HRA Eligible Expenses		$70.00	
	HRA Balance		$ 3.00	

Example 5: No Current Healthcare FSA; Healthcare Expenses = HRA Contribution; No Federal Tax Liability

In this example, the employee does not currently participate in a healthcare flexible spending account. It is assumed that the employee's qualified healthcare expenses equal the employer's HRA contribution. However, due to his/her tax deductions/exemptions, he/she has no federal tax liability.

		Employee's Monthly Income and Taxes		
		Current	with HRA	Change
	Gross Income	$3,300.00	$3,300.00	
-	Health Insurance Premium	$0.00	$100.00	$100.00
-	Healthcare FSA	$0.00	$0.00	$0.00
=	Taxable Income	$3,300.00	$3,200.00	($100.00)
-	Federal Taxes	$0.00	$0.00	$0.00
-	FICA Taxes	$252.45	$244.80	($7.65)
-	State Taxes	$132.00	$128.00	($4.00)
-	Local Taxes	$33.00	$32.00	($1.00)
=	Net Income	$2,882.55	$2,795.20	($87.35)
+	Eligible Healthcare Expenses		$73.00	$73.00
=	Net Income	$2,882.55	$2,868.20	($14.35)
	HRA Deposit		$73.00	
	HRA Eligible Expenses		$73.00	
	HRA Balance		$ 0.00	

Employer Cost Impact

Using the one employee in the preceding examples, the following table illustrates how the employer's cost would be impacted.

		Monthly Employer Cost Impact (One Employee)		
		Current	with HRA	Change
	Salary Expense	$3,300.00	$3,300.00	
+	Health Insurance Premium	$286.00	$186.00	($100.00)
+	FICA Taxes	$252.45	$238.22	($14.23)
+	HRA Contribution		$73.00	$73.00
=	Total Employer Cost	$3,838.45	$3,797.22	($41.23)
+	State Income Tax Reduction		$4.00	$4.00
=	Total Change in Commonwealth's Expense			($37.23)

Considerations

The following are key considerations in evaluating whether to use a health reimbursement arrangement to lower employer health costs by maximizing the tax advantages afforded to employer-sponsored health plans under the federal tax code in the manner described:

- This HRA application variation relies heavily on federal and state income tax savings to keep employees' net income "whole" while reducing the employer's healthcare expenditures. Therefore, employees whose adjusted gross earnings result in no federal and/or state income taxes or lower taxes than assumed in setting the employer's HRA contribution would not come out "whole".
- Employees whose qualified healthcare expenses in a given year are less than the employer's HRA contribution will not come out whole for that year. If unused HRA funds roll over to subsequent years and the employee remains in the employer-sponsored health plan, he/she may recoup this loss in a future year.
- Employees who currently participate in a healthcare FSA will not come out "whole", unless their qualified healthcare expenses exceed their healthcare FSA contribution by the amount of the employer's HRA contribution.
- Social Security benefits, for individuals whose wages are below the Social Security taxable wage base, may be reduced.
- It appears that this arrangement would only apply to active employees, not retirees, since retirees do not have the ability to pay health insurance premiums through a salary reduction arrangement. Therefore, active employees would pay substantially higher health insurance premiums than retirees, but would receive an employer-funded HRA.
- Finally, if the Commonwealth sponsored this type of arrangement, other Kentucky employers may follow suit. This would reduce taxable wages for Kentucky income tax purposes for their employees, thereby reducing state tax revenues.

Health Savings Accounts (HSA's)

The Medicare reform law signed into law by President Bush on December 8, 2003, included a provision that permits individuals who are enrolled in a high-deductible health plan (HDHP), and meet other requirements, to make tax-free contributions to a Health Savings Account (HSA). Health Savings Accounts (HSA's) are tax-exempt trusts that permit tax-free distributions for qualified medical expenses.

Employer involvement is not required. Individuals can establish HSA's on their own.

HSA Contributions

Employers can contribute to HSA's for their employees. Employees can make pre-tax contributions to HSA's through an employer-sponsored cafeteria plan. Individuals who make direct contributions to HSA's may deduct their HSA contributions from their taxable income without itemizing.

Contributions to a HSA are non-forfeitable and portable, as the account is owned by the individual. Any amounts in an HSA at the end of a year carry forward to later years.

Annual combined employer and individual contributions to a Health Savings Account are limited to the lesser of:

- the high deductible health plan annual deductible and
- $2,600 for those with single HDHP coverage or $5,150 for those with family HDHP coverage (the $2,600 and $5,150 are the 2004 limits, these amounts are to be indexed annually).

To avoid a 35% excise tax, if an employer contributes to employees' HSA's, its contribution must be comparable for all HDHP plan participants who are enrolled in the same coverage tier (i.e. single vs. family).

Catch-up contributions are allowed for individuals who are over age 55. The additional annual catch-up contribution for 2004 is $500. This amount is scheduled to increase each year, until it reaches $1,000 in 2009.

Transfers to an HSA are only permitted from an Archer MSA or another HSA. No transfers are allowed from flexible spending accounts (FSA's) or health reimbursement arrangements (HRA's) or IRA's.

High Deductible Health Plans (HDHP's)

In addition to other requirements, individuals cannot contribute to an HSA unless they are enrolled in a high deductible health plan. They cannot be covered by another health plan, except specified limited health plans (e.g., dental, vision, accident, disability, disease-specific plan, workers' compensation auto liability), or Medicare. Also, they cannot be eligible to be claimed as a dependent on another person's tax return.

In 2004, high deductible health plans must meet minimum design criteria:

- the minimum annual deductible must be $1,000 for those with single coverage and $2,000 for those with family coverage;
- the annual out-of-pocket limit can be no more than $5,000 for those with single coverage and $10,000 for those with family coverage.

Both the minimum annual deductibles and the maximum out-of-pocket limits are to be indexed annually.

Unlike many health plans, for HDHP's, the family deductible is not a family limit on individual deductibles. Rather, in aggregate, all covered family members' eligible expenses must exceed the family deductible before the plan pays benefits.

Preventive care can be subject to separate provisions, and may be covered up to 100%.

After January 1, 2006, a HDHP that covers prescription drugs must treat prescription drugs like all other covered expenses, other than preventive care. Prescription drugs cannot be carved out under a separate plan.

HSA Distributions

Tax-free distributions are allowed from HSA's for qualified medical expenses. And, an individual does not have to be enrolled in a HDHP at the time of the distribution.

Premium payments generally do not qualify for a tax-free distribution. However an exception exists for:

- COBRA premiums,
- health insurance coverage while on unemployment compensation,
- premiums paid after age 65, other than for Medigap coverage, and
- long-term care insurance premiums.

Other distributions are permitted. However they are taxable and generally subject to a 10% tax penalty.

Qualified Trustees and Custodians

Insurance companies, banks, and entities already approved by the IRS to be an IRA or Archer MSA trustee/custodian, plus others who request and receive IRS approval can be a qualified HSA trustee or custodian.

Summary

The following summary contrasts HSA's with HRA's and FSA's.

	Health Savings Account (HSA)	Health Reimbursement Account (HRA)	Flexible Spending Account (FSA)
Eligibility	Individuals with high-deductible plan (HDHP) and no other coverage	Employees whose employers make available	Employees whose employers make available
Health Insurance Requirement	Qualified high-deductible health plan required	None, except by employer plan design	None
Contributions	Employer, employee, or both	Employer only	Employer, employee, or both
Contribution Availability	Pro-rata each month that HDHP coverage in effect	Employer can decide – typically, full amount available 1st day	Full amount must be available first day
Annual Contribution Limits	Lesser of 100% of HDHP deductible or $2,600 (single); $5,150 (family) for 2004 – indexed annually	None legally required; employer sets its contribution amounts	None legally required, employer sets employee contribution limits
Qualifying expenses	Miscellaneous IRC 213(d) expenses, limited health premiums ***Not determined by employer***	Miscellaneous IRC 213(d) expenses, unlimited health premiums ***Subject to employer's design***	Miscellaneous IRC 213(d) expenses, no health premium reimbursements ***Subject to employer's design***
Nonqualified Withdrawals	Yes, but taxable, plus 10% penalty. After age 65, death or disability - no penalty	Not allowed	Not allowed
Unused Funds	Unused funds roll over	Rollover allowed, although employer can establish limits	Rollover not allowed
Forfeitability	Non forfeitable, fully portable, can take to new employer	COBRA rights apply	Limited COBRA rights apply

Due to the education required and information needed to be an informed consumer under a CDHP or HDHP, the Board recommends that the Commonwealth continue to study HRA's and/or HSA's for the PEHI program, as health services and provider cost and quality information becomes available to PEHI members.

Timing of Board's Annual Report

Statutorily, the Board's report to the Governor, General Assembly, and Chief Justice of the Supreme Court, which contains the Board recommendations, is due October 1 of each year. This year, the Commonwealth did not execute contracts with insurers and third party administrators for 2005 until mid August. Therefore, Board members were left with only two weeks to assimilate the PEHI program revisions to become effective January 1, 2005 and modify its report and recommendations accordingly.

To address this concern, the Board recommends that the deadline for its annual recommendations be revised from October 1, to December 1.

Program Administration and Governance

To encourage insurance carriers and third-party administrators to provide good quality service to Public Employee Health Insurance Program members, the Department for Employee Insurance, and its benefit coordinators, the Commonwealth has incorporated performance guarantees in its health insurance contracts, with monetary penalties if performance standards are not met. The Department for Employee Insurance receives periodic reports from each of the PEHI program's insurance carriers outlining their performance in relation to the performance guarantees to which they agreed and holds meetings and conference calls with the insurance carriers as necessary for continuous quality improvement. However, the Commonwealth's ability to monitor the performance of its insurance carriers and recommend revisions to improve performance over time could be enhanced if independent audits were conducted by the Department for Employee Insurance, another Commonwealth agency, or an independent third party, periodically to verify vendors' reported financial and performance results.

Legislative Mandates

The Department of Insurance provided the summary in Exhibit XXIII of twenty-nine mandated health insurance benefits that currently exist in Kentucky's statutes.

Exhibit XXIII

Kentucky Mandated Health Insurance Benefits	
Newborn Coverage	KRS 304.17-042, KRS 304.18-032, KRS 304.32-153, and KRS 304.38-199. Coverage for newborn children from the moment of birth, including necessary care and treatment of medically diagnosed inherited metabolic diseases for newborns—KRS 304.17A-139(2)
Inherited Metabolic Disease	KRS 304.17A-139(4). Coverage for amino acid modified preparation and low protein modified food products for treatment of inherited metabolic diseases for conditions listed in KRS 205.560, if prescription drugs are covered. Benefits can be limited to $4,000 per year for low-protein modified foods and $25,000 per year for medical formulas.
Ambulatory Surgical Centers	KRS 304.17-317, KRS 304.18-035, & KRS 304.32-156. Coverage for treatment at ambulatory surgical centers.
Optometrists, osteopaths, physicians, podiatrists, and chiropractors	KRS 304-17-035, KRS 304.18-095, KRS 304.32-157 & KRS 304.38-195. KRS 304.17A-275 requires that coverage be provided for services provided by osteopaths. Osteopaths can also be PCP's. Services of these providers to be covered as described.
Chiropractors	KRS 304.17A-170 & 171. Access to chiropractors in network plans.
Dentists	KRS 304.17-315, KRS 304.18-097, KRS 304.32-157 & KRS 304.38-1937. Services of dentists to be covered as described.
Temporomandibular Joint Disorder	KRS 304.17-319, KRS 304.18-0365, KRS 304.32-1585 & KRS 304.38-1937. Coverage for specific services related to TMJ and associated disorders. Also see Administrative Regulation 806 KAR 17:090.
Screening Mammography	KRS 304.17-316, KRS 304.18-098, KRS 304.32-1591 & KRS 304.38-1935. Screening mammography at specific intervals. KRS 304.17-316(2)(b) requires mammography coverage at any age for a covered person diagnosed with breast cancer.
Breast Cancer	KRS 304.17-3165, KRS 304.17A-135, KRS 304.18-0985, KRS 304.32-1595 & KRS 304.38-1936. Coverage for the treatment of breast cancer, including ABMT.
Breast reconstruction coverage, endometriosis and endometritis	KRS 304.17-3163, KRS 304.18-0983, KRS 304.38-1934, KRS 304.32-1593 & KRS 304.17A-134.
Psychologists and Clinical Social Workers	KRS 304.17-3185, KRS 304.18-0363, KRS 304.32-166 & KRS 304.38-1933. Services of these providers to be covered as described.
Registered nurse first assistant benefits	KRS 304.17A-146. Health benefit plans that cover surgical first assisting benefits or services must provide coverage for a registered

Kentucky Mandated Health Insurance Benefits	
	nurse first assistant who performs the services within the scope of their license.
Conversion benefits	2002 Ky. Acts, Chapter 351, Section 9. Maximum benefits of at least $500,000 for conversion policies—KRS 304.18-120(1). Minimum benefits—806 KAR 17:260.
Work Related Illness/Injuries	KRS 304.12-250. No contract can exclude coverage solely on the basis that the health condition is work related.
Disabled Children	KRS 304.17-310. Individual health insurance contracts must continue coverage for disabled children beyond the limiting age. Although this statute is applicable only to individual contracts, group carriers commonly use it.
Adopted Children	KRS 304.17-140. Coverage for legally adopted children or children under court-appointed guardianship.
Human Immunodeficiency Virus	KRS 304.12-013(5). No insurer or HMO may exclude or limit coverage for AIDS, etc.
Maternity Coverage	KRS 304.17A-145. Specified length of hospital stay following vaginal/cesarean deliveries.
Cochlear Implants	KRS 304.17A-131. Coverage for cochlear implants.
Autism	KRS 304.17A-143. Coverage for autism, including respite services.
Diabetes	KRS 304.17A-148. Coverage for diabetic services, supplies, and training.
Women's Health	KRS 304.17A-134, KRS 304.17-3163, KRS 304.18-0983, KRS 304.32-1593 & KRS 304.38-1934. Breast reconstruction, endometriosis, endometritis, and bone density testing.
Domestic Violence	KRS 304.17A-155. Claims may not be denied or considered pre-existing on the basis of domestic violence.
Hospice	KRS 304.17A-250(8). Coverage for hospice care equal to Medicare benefits.
Telehealth services	KRS 304.17A-138. (Effective when the plans are issued or renewed after July 15, 2001)
Mental health coverage	KRS 304.17A-661. Large group health benefit plans must cover mental illness the same as physical illness, if they provide mental illness benefits.
Physician assistant benefits	KRS 304.17A-1473. Health Benefit Plans that cover surgical first assisting or intraoperative surgical care services must provide coverage for the services of a physician assistant. (Effective for Health Benefit Plans issued or renewed on or after July 15, 2001.)
Anesthesia and hospital or facility charges	2002 Ky. Acts, Chapter 199. Requires coverage for payment of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems in all health benefit plans that provide coverage for general anesthesia and hospitalization services.

Kentucky Mandated Health Insurance Benefits	
Hearing aids and related services	2002 Ky. Acts, Chapter 106, Section 1(2). Requires coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.

Source: Kentucky Department of Insurance

In addition to the mandated benefits outlined in Exhibit XXIII, there are other statutory requirements that affect the Public Employee Health Insurance Program. Exhibit XXIV provides a brief outline of the key provisions of the mandates enacted by the 2000 General Assembly that apply to health insurance programs. The provisions of those bills for which there is no check mark in the column titled "Impacts Commonwealth Plan" were covered by the Commonwealth's Public Employee Health Insurance Program prior to the enactment of the mandate.

Exhibit XXIV

	Health Insurance Mandates Enacted by 2000 General Assembly	
	Impacts Commonwealth Plan	Key Provisions
HB 9		Mammography coverage
HB 177		Coverage of telehealth services
HB 202	✓	▪ Newborn coverage from moment of birth ▪ Treatment of inherited metabolic diseases including amino acid preparations and low-protein modified food products
HB 268	✓	Mental Health Parity
HB 281		Coverage of services provided by registered nurse first assistants
HB 390	✓	▪ Utilization review rules ▪ Independent external review
HB 757	✓	▪ Hold harmless and continuity of care upon contract termination ▪ Drug formulary summary required at enrollment ▪ Network access requirements modified ▪ Prudent lay person standard for emergency services
SB 279	✓	Prompt payment of medical claims
SB 335	✓	Coverage of certified surgical assistants

In addition to the health insurance mandates, Senate Bill 288, enacted by the 2000 General Assembly:

- Created the Kentucky Group Health Insurance Board.
- Required the Personnel Cabinet to develop healthcare data collection and analysis capabilities.
- Stipulated the conditions under which groups may leave the Public Employee Health Insurance Program.
- Revised the definition of "employee" with respect to the Commonwealth's healthcare and flexible spending account benefits.
- Required the Personnel Cabinet to report annually to the General Assembly on the financial stability of the Commonwealth's Public Employee Health Insurance Program.
- Required unused flexible spending account funds to be transferred to the state health insurance plan's appropriation account.
- Required carriers bidding to offer healthcare coverage to members of the Public Employee Health Insurance Program to rate all such members as single entity, except for those retirees whose former employers insure their active employees outside the Public Employee Health Insurance Program.
- Precluded certain individuals who are eligible for participation in the Public Employee Health Insurance Program as a retiree from receiving the state health insurance contribution as an active employee as well.

Additional mandates enacted by the 2001, 2002, and 2003 General Assemblies affect the Commonwealth's Public Employee Health Insurance Program. These are summarized briefly in Exhibit XXV.

Exhibit XXV

Legislation Enacted by the 2001, 2002, and 2003 General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	**Bill**	**Key Provisions**
2001	HB 97	The Office of Public Employee Health Insurance was established under the Personnel Cabinet.
2001	HB 138	Coverage of physician assistants assisting in surgery.
2001	HB 145	Personnel Cabinet and Cabinet for Families and Children to prepare recommendations regarding allowing foster parents to participate in the Public Employee Health Insurance Program.
2002	HB 39	Coverage of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems.
2002	HB 163	Expands Kentucky Group Health Insurance Board to include: ▪ The Director of the Administrative Office of the Courts ▪ KRS retiree ▪ KTRS retiree ▪ Active teacher ▪ Active state employee ▪ Active classified education support employee
2002	HB 369	Mail order prescription drug coverage for Public Employee Health Insurance Program.
2002	HB 395	Revised caps for inherited metabolic diseases to be $4,000 annually for low-protein modified foods and $25,000 annually for medical formulas.
2002	HB 801	Entities that join the Kentucky Retirement System must join the Public Employee Health Insurance Program for their active employees.
2002	HB 821	▪ Personnel Cabinet to study whether to allow health insurance bidders to bid different rates in different geographic areas of the Commonwealth. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state contribution for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.

Legislation Enacted by the 2001, 2002, and 2003 General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	**Bill**	**Key Provisions**
2002	HB 846	▪ Restricts individuals to one state contribution for health insurance. ▪ Entities participating in the Public Employee Health Insurance Program must sign a contract with the Personnel Cabinet. ▪ Expands the Advisory Committee of State Health Insurance Subscribers to include 2 members from the Kentucky Association of Counties and 2 from the Kentucky League of Cities. ▪ Directs the LRC to study the cost to members of the state health insurance group as a result of entities covering their retirees under the Public Employee Health Insurance Program but not their active employees and recommend administrative procedures to collect this cost from these entities. ▪ Directs the LRC to study the Public Employee Health Insurance Program. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state contribution for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.
2002	SB 152	Coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.
2002	SCR 34	Directs the Interim Joint Committee on Banking and Insurance to study the feasibility of self-funding at least one health insurance option for state employees.
2003	HB 95	Removes the requirement that an employee's employment must be in the same county as his residence for the employee to be eligible to elect coverage in an adjacent county and receive the state contribution for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does.
2003	HB 183	Requires that the sponsor of a bill that contains a mandated health benefit request, have prepared, and attach a financial impact statement before final consideration by a standing committee.
2003	HB 370	Required the Commonwealth's Public Employee Health Insurance Program to include a scenario that allows regional rating in its 2004 health insurance Request for Proposal, with regions defined as the partnership regions designated by the Department for Medicaid Services.
2003	HB 430	For individuals hired on or after July 1, 2003, increased the service required of participants in SPRS, CERS or KERS from a minimum of 5 years to 10 years to be eligible to participate in the Commonwealth's retiree health insurance program.

No additional benefit mandates were enacted by the 2004 General Assembly. In fact, House Bill 650 created a new statute in Subtitle 17A that imposes a 3-year moratorium on new mandated benefits, beyond those statutorily required on July 13, 2004.

Conclusions

There are a significant number of legislative mandates that apply to the Commonwealth's Public Employee Health Insurance Program. The impact of many of these mandates on the program's costs is difficult to discern. And, although the discernible cost of some mandates may be low in a given year, significant variation can result from year to year. Finally, the ability to determine the cost of discrete provisions is highly dependent on providers appropriately classifying the expenses and insurance carriers accurately recording the expenses. Therefore, the cost impact can easily be understated.

Conclusions

This section provides a consolidated summary of the conclusions presented in the previous sections of this report. The Board's recommendations, based on these findings, are outlined in the Executive Summary. After presenting some general observations about the program, the remaining findings are organized in the four categories in which the Board's recommendations are presented:

- Consumer information and education,
- Health benefit provisions,
- Program governance, and
- Program administration.

General Observations about the Public Employee Health Insurance Program

- The total dollars retained by the Commonwealth's insurers to cover administrative expenses and profit declined from roughly $51 million in 2002 to about $34 million in 2003 (about $20 per employee/retiree per month). With claims increases outpacing premium increases since 2001, the Commonwealth and its members should anticipate significant premium increases in 2005, unless program changes are implemented

- Based on its historical experience and increasing percentage composition of retirees, the Commonwealth's health insurance costs are expected to continue to increase at levels well in excess of general inflation for the foreseeable future.

- Without a change in the Commonwealth's contribution policy – paying the full cost of single coverage for the lowest cost A option with no subsidy for dependent premiums – it is anticipated that the percentage of Public Employee Health Insurance Program members enrolling their dependents will continue to decline, as it has continually since 1999.

- Participation in a pharmacy benefit purchasing cooperative could lower the Commonwealth's prescription drug costs by 3% to 10% and provide more consistent pharmacy benefit administration (formularies, step-therapy, quantity limits, etc.) to members of the Public Employee Health Insurance Program. However, from a practical perspective, participation in a pharmacy benefit purchasing cooperative will only be an option for the Commonwealth if it decides to self-fund its health insurance benefits at some point in the future.

Consumer Education and Information

Due to the impact of employer-sponsored health plans, unlike other factions of the U.S. economy, the healthcare market does not operate "efficiently". The insured consumer's choices about which doctor to use, when to seek care, and how to manage his or her health, have had relatively little impact on his or her direct out-of-pocket expenses. Furthermore, most consumers of health care, like members of the PEHI program, have little access to information about health care services, products, prices, quality, or relative value. And, studies indicate that health care provider quality and "efficiency" varies significantly.

As more financial responsibility is placed on health plan members at the time they consume health care services, members will demand more information and decision support systems to assist them in using the information. This information is necessary for individuals to make informed healthcare decisions.

Some experts believe that the dissemination of information about health care costs and quality will encourage innovation and quality enhancements, as consumer buying power has with other goods and services.

Similar to other employer-sponsored health plans, there is wide diversity in health status among PEHI members. Additionally, in the PEHI program, similar to Kentucky overall, there is a high prevalence of chronic health conditions.

Research shows that behavior is a far more significant driver of health status than environment, genetics or access to health care. In fact, its impact is as powerful as all three of these other factors combined. Poor health status and inappropriate use of health care services are outcomes that can be changed through behavior modification. However, behavior modification cannot take place without education. To address the wide spectrum of health statuses that exists within the PEHI program membership, educational outreach efforts should be broad-based.

Health Benefits Provisions

- With the exception of dependent health insurance contributions, the provisions of the Commonwealth's 2003 health offerings were more generous than the median of the large employer market and that of other state governments. This differential is expected to increase in 2004, as other employers expected to further increase member cost sharing, while the provisions in the Commonwealth's plans remained basically the same.

  However, some members of the Board feel that it is important for the Commonwealth to view its health insurance benefits in the context of its total compensation program. In this context, these Board members generally believe that the Commonwealth's health benefit plan provisions must be above the median of the market in order to attract and retain qualified employees.

- Public Employee Health Insurance program members' 2003 dependent health insurance premium contributions were 2 to 3 times the market average for large, national employers and state government employers. The magnitude of these contributions has contributed to a continual decline in the percentage of Public Employee Health Insurance Program members enrolling their dependents in the Commonwealth's program. Without a change in the Commonwealth's contribution policy – paying the full cost of single coverage for the lowest cost A option available in each county with no subsidy for dependent premiums – it is anticipated that the percentage of Public Employee Health Insurance Program members enrolling their dependents will continue to decline, as it has since 1999.

- Health Reimbursement Accounts (HRA's) are often a component of consumer-directed health plans (CDHP's). HRA's are similar to healthcare flexible spending accounts, with a couple of key exceptions:

  - they are employer-funded and do not permit employee contributions of any sort, and
  - all or a portion of unused funds at the end of one year carry over to the next year.

  In a variation of the typical HRA, some entities have considered using a health reimbursement arrangement to lower employer health costs by maximizing the tax advantages afforded to employer-sponsored health plans under the federal tax code. However, this HRA application relies heavily on federal and state income tax savings to keep employees' net income "whole" while reducing the employer's healthcare expenditures. Therefore, employee reaction to this approach to an HRA would seem to be highly dependent on the employee's tax situation. Finally, if the Commonwealth sponsored this type of arrangement, other Kentucky employers may follow suit. This would reduce taxable wages for Kentucky income tax purposes for their employees, thereby reducing state tax revenues.

  As an alternative to a HRA, the Commonwealth might consider implementing a high-deductible health plan (HDHP) in conjunction with a Health Savings Account, a new tax-favored vehicle that came into existence through the Medicare reforms enacted in 2003. There are several key differences between HSA's and HRA's:

  - Only employees enrolled in a high-deductible health plan that meets federal requirements may make HSA contributions.
  - HSA's are owned and controlled by individuals. Therefore, when an individual terminates his/her employment, his/her HSA is not affected.
  - Whether a distribution from a HSA is taxable or not is based on federal tax laws and regulations, not the provisions of an employer's plan. Generally, HSA's are broader in the healthcare expenses that they cover on a tax-favored basis than HRA's. And, unlike HRA's, HSA's permit taxable distributions, in most cases with a tax penalty applied, for expenses other than healthcare expenses.

- Anecdotally, some Board members have heard that, due to the magnitude of employee contributions for dependent health insurance, some Commonwealth employees have opted to waive health insurance coverage through the PEHI program and use the healthcare FSA funded by the Commonwealth to pay their family's health care expenses. These stories create Board concerns about the reduction in healthcare FSA funding for employees who waive health insurance that is planned for 2005.

Program Governance

- The percentage of Public Employee Health Insurance members that retirees and their covered dependents comprise grew from 14.3% in 1999 to over 20% by the end of the first quarter of 2004. Due to the impact of age on individuals' health care costs, this trend has significant cost implications for the Commonwealth's Public Employee Health Insurance Program. This impact is exacerbated by the entities whose retirees participate in the Commonwealth's program whose active employees do not – municipalities and other local governmental bodies and regional universities that participate in a state-sponsored retirement plan. As indicated in the Board's October 2002 report, supported by an independent analysis conducted by The Segal Company at the request of the Interim Joint Committee on State Government, these "unescorted" retirees added between $14 and $16 million in excess claims to the Public Employee Health Insurance Program in 2001. By calendar year 2003, these additional claims grew to about $21 million. This equates to PEHI program costs that were about 3.3% higher than they otherwise would have been

- Currently, the Board is required to submit its recommendations to the Governor, General Assembly and Chief Justice of the Supreme Court by October 1 of each year. As contracts for the PEHI program's calendar 2005 plan year were not executed until mid August, the Board was left with a very short timeframe in which to ensure that this report reflected appropriate recommendations and analysis considering the significant changes occurring in the PEHI program in 2005.

Program Administration

To encourage insurance carriers and third party claims administrators to provide good quality service to Public Employee Health Insurance Program members, the Department for Employee Insurance, and its benefit coordinators, the Commonwealth has incorporated performance guarantees in its health insurance contracts, with monetary penalties if performance standards are not met. The Department for Employee Insurance receives periodic reports from each of the Commonwealth's health insurance carriers outlining their performance in relation to the performance guarantees to which they agreed and holds meetings and conference calls with the insurance carriers, as necessary, for continuous quality improvement. However, the Commonwealth's ability to monitor the performance of its insurance carriers and recommend revisions to improve performance over time could be enhanced if on-site performance reviews were conducted by the Department for Employee Insurance, or an independent third party, periodically to verify carriers' reported financial and performance results.

Glossary

Allowed Charge – The amount paid in total to a healthcare provider for services received by a health plan member. This amount includes both the health plan's payment and the member's cost sharing (deductible, co-payment, co-insurance, etc.). This is the total amount billed by a healthcare provider for a covered service, after the application of the health plan's negotiated discount, but prior to any member cost-sharing.

Brand Name Drug – A trademarked drug for which the manufacturer holds the patent or has purchased the rights to manufacture from the patent holder. Brand name drugs are generally more expensive than generics. A single-source brand name drug is a drug that is only produced by one manufacturer and for which a generic equivalent is not available. Multi-source brand name drugs are drugs produced by more than one manufacturer, as generic equivalents are available.

Capitation – A set amount of money paid to a provider of service based on membership demographics rather than payment based on services provided.

Claim – A billed amount for services or goods obtained from a healthcare provider.

COBRA Beneficiaries - Individuals who no longer meet the eligibility requirements for healthcare coverage through a group health plan, but by federal statute, are eligible to continue their healthcare coverage for a period of time under the employer's healthcare program by paying 102% of the total premium rate.

Co-Payment – A stipulated dollar amount that a health plan member must pay out of pocket when healthcare services, supplies, or prescription drugs are received.

Coinsurance – A percentage of the cost of covered healthcare services, supplies, or prescription drugs that a health plan member must pay out of pocket.

Coverage Tier also referred to as Coverage Level – The choices available to employees with respect to the individuals they wish to cover under an employer's health insurance program. Under the Commonwealth's Public Employee Health Insurance Program, the following tiers (or levels) apply:

- Single – coverage for only the employee or retiree
- Couple – coverage for the employee or retire and his/her spouse
- Parent Plus – coverage for the employee and all eligible children
- Family – coverage for the employee or retiree, his/her spouse and all eligible children

Dependent Subsidy – When an employer specifically pays a portion, or all, of the dependent premium for an employee, this is an *explicit dependent* subsidy. When the differential between single and dependent healthcare premium rates is less than the differential between employee/retiree healthcare claims and dependents' healthcare claims, an *implicit dependent subsidy* exists.

EPO – Exclusive Provider Organization - These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Depending on the insurance carrier chosen, the participant may or may not have to designate a primary care physician to coordinate his/her care. Beginning January 1, 2000, EPO Option C was added to the Commonwealth's Public Employee Health Insurance Program.

Formulary – A preferred list of medications developed by a health plan or Pharmacy Benefit Manager (PBM) to guide physician prescribing and pharmacy dispensing. This list is periodically updated by the PBM to add or remove drugs.

FSA – Flexible Spending Account – A flexible spending account or reimbursement account is funded by employee salary reductions, employer contributions or both. Amounts placed in these accounts are used to provide reimbursement for eligible expenses incurred by the employee or eligible beneficiaries for specified benefits during a plan year.

Fully Insured - also referred to as Insured or Fully Funded - When a health plan assumes the financial risk associated with medical expenses for an employer group in exchange for the premiums paid by the group.

Generic Drug - A drug whose therapeutical ingredients are the same as a brand name drug, but which is sold under a name that is not trademarked. Generic drugs are usually less expensive than their brand name counterpart.

HMO – Health Maintenance Organization - These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Participants in these plans must select a primary care physician to coordinate their care. For the majority of the services covered by the HMO, participants pay a specified dollar amount (co-payment) at the time services are received.

Medical Loss Ratio also referred to as Loss Ratio - The ratio between the incurred claims paid by a health plan and the premium taken in by the health insurer. Example: An insurance company receives $100,000 in premium for a month and pays out $89,000 in claims – the Medical Loss Ratio is 89% ($89,000/$100,000).

Out-of-Pocket Limit – A specified dollar amount present in some health plan provisions that limits the amount of out-of-pocket expenses a plan participant pays in a Plan Year for covered health care services. Once the participant reaches the out-of-pocket limit, the health plan pays 100% of his/her covered healthcare expenses for most or all services.

PBM – Pharmacy Benefit Manager – An organization that functions as a third party administrator for a health plan's pharmacy claims, contracts and management.

POS – Point of Service - These plans mimic the benefits of the HMO options, provided an individual receives services from a healthcare provider that has contracted with the health plan and services are coordinated through the primary care physician designated by the individual. Unlike the HMO options, the POS options provide coverage for services received from a provider that is not in the health plan's network, at a higher cost sharing percentage to the insured.

Preferred Provider Organization (PPO) - These plans require lesser cost sharing from participants, if covered services are received from a healthcare provider that participates in the health plan's network. Coverage is provided for services received from a provider that is not in the health plan's network, with participants paying a larger proportion of the cost of covered services. Unlike POS plans, PPOs do not require referrals from a participant's primary care physician. The PPOs offered under the Commonwealth's Public Employee Health Insurance Program provide the same benefits for services received in a network physician's office and for prescription drugs as do the HMO and POS options. However, for services received in a network hospital or surgical center, PPO participants pay a percentage of the cost of services received (co-insurance) after paying an annual deductible, rather than a specified dollar co-payment. The amount of co-insurance that a participant pays annually is capped by the PPO plan's out-of-pocket limit.

Premium – The monetary amount paid by an employee or the employer for health insurance benefits. Routinely paid on a monthly basis. In an insured program, the amount paid to an insurance company in exchange for its payment of all healthcare costs covered under the terms of the health plan and for administrative services. For large groups, like the Public Employee Health Insurance Program, premiums are determined based on the healthcare services consumed by the plan's members in the past and the prices charged by healthcare providers. If the premiums charged by the insurer are less than the actual healthcare costs incurred by the plan's members and the insurer's operating costs, the insurer loses money. The premium includes both the employer's and employees' contributions for health insurance.

Primary Care Physician – For purposes of the applying the Commonwealth's qualifying network requirements, a primary care physician includes: family practice physicians, general practice physicians, pediatricians, and internists.

Provider Network – A list of contracted health care providers, unique to a health plan, from which an insured can obtain services that are covered under an HMO or are covered at a preferred benefit level under a POS or PPO.

Self Insured – also referred to as Self Funded – A health plan whose medical claims' financial risk is assumed by the employer and not by the health plan.

Specialist Physician – For purposes of the applying the Commonwealth's qualifying network requirements, a specialist physician includes all physicians other than: family practice physicians, general practice physicians, pediatricians, and internists.

Stop Loss Coverage - Stop loss coverage is insurance that covers a health plan's expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). This coverage is also referred to as **Excess Loss Coverage.**

Third Party Administrator (TPA) – An organization that performs health insurance administrative functions (e.g. claims processing) for a plan or an employer. The TPA may also provide the healthcare provider network.

Unescorted Retirees - Individuals who participate in a state sponsored retirement program are eligible to participate in the Public Employee Health Insurance program. These retirees include not only former employees of state agencies and school districts, but also former employees of cities, counties, and municipalities that participate in the County Employees Retirement System (CERS) and former employees of regional universities. Health insurance coverage for the pre-65 retirees of the Commonwealth's KTRS, KERS, SPRS and CERS programs is provided through the same program that covers active state employees. However, active employees of the Commonwealth's regional universities do not participate in the Public Employee Health Insurance program, neither do active employees of most of the cities, counties and municipalities that participate in the CERS program. Rather, these entities maintain separate health insurance programs for their active employees. In the analysis conducted by the Segal Company in October 2002 at the request of the Interim Joint Committee on State Government, the term "unescorted retirees" was assigned to this group of retirees.

Waiver - An eligible employee or retiree who declines health care coverage through his/her employer for a plan year. Often the employee obtains health care coverage through another means, typically a spouse's employer or an individual.

2002 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person, per plan year; one set of bitewing x-rays per person per plan year.	50% co-insurance; $100 maximum benefit per plan year.	Not covered
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-insurance; $75 maximum benefit per plan year.	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2002 Public Employee Health Insurance Program Benefit Provisions

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins $100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins $75 maximum benefit per year		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness,or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance*	50% co-insurance	50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

2002 Public Employee Health Insurance Program Benefit Provisions

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits and coinsurance amounts for dental, vision, audiometric and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit) $400 maximum benefit per year	40% co-ins*	$20 co-pay (per visit) $300 maximum benefit per year	50% co-ins*
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins* $100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins* $75 maximum benefit per year		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins* Limit 60 visits per year.	40% co-ins*	25% co-ins* Limit 40 visits per year.	50% co-ins*
	Autism Respite Services – $500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-ins*	50% co-ins*	50% co-ins*	50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

2002 Public Employee Health Insurance Program Benefit Provisions

Exclusive Provider Option		Option C
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Coinsurance amounts for autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs	Copay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Respite Services – $500 maximum monthly benefit for children 2 - 21 years of age for respite and rehabilitative care.	50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay

2003 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary	$20 generic $30 brand $60 non-formulary
Dental		Not Covered	Not covered
Vision		Not Covered	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 $20 co-pay 50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 40% co-ins* 50% co-insurance*	 $20 co-pay 50% co-insurance	 50% co-ins* 50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
		$400 maximum benefit per year		$300 maximum benefit per year	
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age				
	• Rehabilitative and Therapeutic care	$10 co-pay	40% co-ins*	25% co-ins*	50% co-ins*
	• Respite Care	50% co-ins*	50% co-ins*	50% co-ins*	50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$50 generic $70 brand $100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age	
	• Rehabilitative and Therapeutic care	$25 co-pay (per visit)
	• Respite Care	50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay

*Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered.

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2004 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary	$20 generic $30 brand $60 non-formulary
Dental		Not Covered	Not covered
Vision		Not Covered	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 $20 co-pay 50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

2004 Public Employee Health Insurance Program Benefit Provisions

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 40% co-ins* 50% co-insurance*	 $20 co-pay 50% co-insurance	 50% co-ins* 50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

2004 Public Employee Health Insurance Program Benefit Provisions

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit)	40% co-ins* $400 maximum benefit per year	$20 co-pay (per visit)	50% co-ins* $300 maximum benefit per year
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins*	40% co-ins* Limit 60 visits per year.	25% co-ins*	50% co-ins* Limit 40 visits per year.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age				
	• Rehabilitative and Therapeutic care	$10 co-pay	40% co-ins*	25% co-ins*	50% co-ins*
	• Respite Care	50% co-ins*	50% co-ins*	50% co-ins*	50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

2004 Public Employee Health Insurance Program Benefit Provisions

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$50 generic $70 brand $100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age	
	• Rehabilitative and Therapeutic care	$25 co-pay (per visit)
	• Respite Care	50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay